OKLAHOMA
Health Care Authority

Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness/Substance Use Disorder

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Contents

I. EXECUTIVE SUMMARY

The Oklahoma Health Care Authority (OHCA), in coordination and collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), seeks authorization for a Section 1115(a) demonstration waiver to support a more robust and coordinated continuum of care for adults with serious mental illness (SMI) and substance use disorder (SUD). Like many states, Oklahoma has been significantly affected by the opioid epidemic, and the State continues to experience high rates of SMI and SUD. Oklahoma's ballot measure to expand Medicaid, State Question 802 (SQ 802), will be decided by voters on June 30, 2020. Should the measure pass, Medicaid expansion is anticipated to begin by July 1, 2021. The current outpatient behavioral health and addiction recovery delivery system is primed for a new influx of Medicaid-eligible adults if SQ 802 passes and subsequently expands Medicaid in Oklahoma. Through this waiver application submission, the State seeks to provide richer coverage for higher-intensity services in recognition that robust support of the full continuum of care will promote better outcomes, support recovery, reduce health care costs, and improves the lives of beneficiaries.

Specifically, Oklahoma requests Medicaid reimbursement for medically necessary residential substance use disorder (SUD) treatment, facility-based crisis stabilization, and inpatient treatment services within settings that qualify as institutions for mental disease (IMDs). The goal of the State is to increase access to evidence-based treatment options for Medicaid eligible adults ages 21-64 with SMI and/or SUD to appropriately address acute behavioral health needs, improve rates of morbidity and mortality for covered populations, and decrease utilization of less appropriate services, such as emergency room visits. The State also seeks to include residential IMD SUD services for individuals under 21 years of age under this waiver, as well as Qualified Residential Treatment Programs (QRTPs), that are determined by the State to meet the definition of an IMD, when they are implemented.

Oklahoma is dedicated and prepared to ensure access to residential and inpatient treatment settings when medically necessary and when other less restrictive settings and services are not in the best interest of the individual. The State also remains committed to maintaining a robust continuum of community-based outpatient services and supports and will enhance current efforts to support a coordinated system of care to promote more successful outcomes and prevent readmissions. Oklahoma's current service delivery system includes a number of innovative service delivery models. Particularly, within the last several years, the State has demonstrated its commitment to a responsive and coordinated statewide system of care through implementation of models such as Health Homes and Certified Community Behavioral Health Clinics (CCBHCs). The State also has a robust crisis assessment and diversion system to support the placement of individuals in least restrictive settings. Oklahoma's wide array of outpatient services is available to both Medicaid enrollees and certain low-income individuals not currently eligible for Medicaid. Medicaid expansion in the state, should it occur, will increase availability of these services for newly eligible adults, which will in turn may reduce the need for inpatient and residential treatment for the new population of Medicaid beneficiaries.

The State requests an effective date for this demonstration waiver of October 1, 2020. The State posted this application for public review and comment on May 1, 2020. The posted application assumed Medicaid expansion on July 1, 2020; however, Medicaid expansion is no longer anticipated to take place on that date. The State withdrew its Title XIX state plan requesting authority to expand Medicaid in Oklahoma on July 1, 2020. A ballot measure to expand Medicaid will be decided by Oklahoma voters on June 30, 2020. If passed, the measure will implement Medicaid expansion by July 1, 2021.

The State submitted an 1115 Healthy Adult Opportunity waiver application on May 6, 2020; the application is currently undergoing federal public comment period. Implications of that waiver, should it be approved, are referenced within this waiver application.

This updated application reflects the current eligibility system while acknowledging that significant changes to enrollment could occur due to Medicaid expansion.

II. PROGRAM BACKGROUND AND DESCRIPTION

Overview of Oklahoma's Behavioral Health Service Delivery System

The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work collaboratively to provide a wide array of behavioral health services for Oklahomans. Medicaid compensable inpatient services are largely administered by the OHCA, while Medicaid compensable outpatient behavioral health services and other state-funded supports are largely administered by the ODMHSAS. A combined payer system consolidates eligibility determinations, claims, authorizations, and outcomes data for publicly funded services, including both Medicaid compensable and state-funded services.

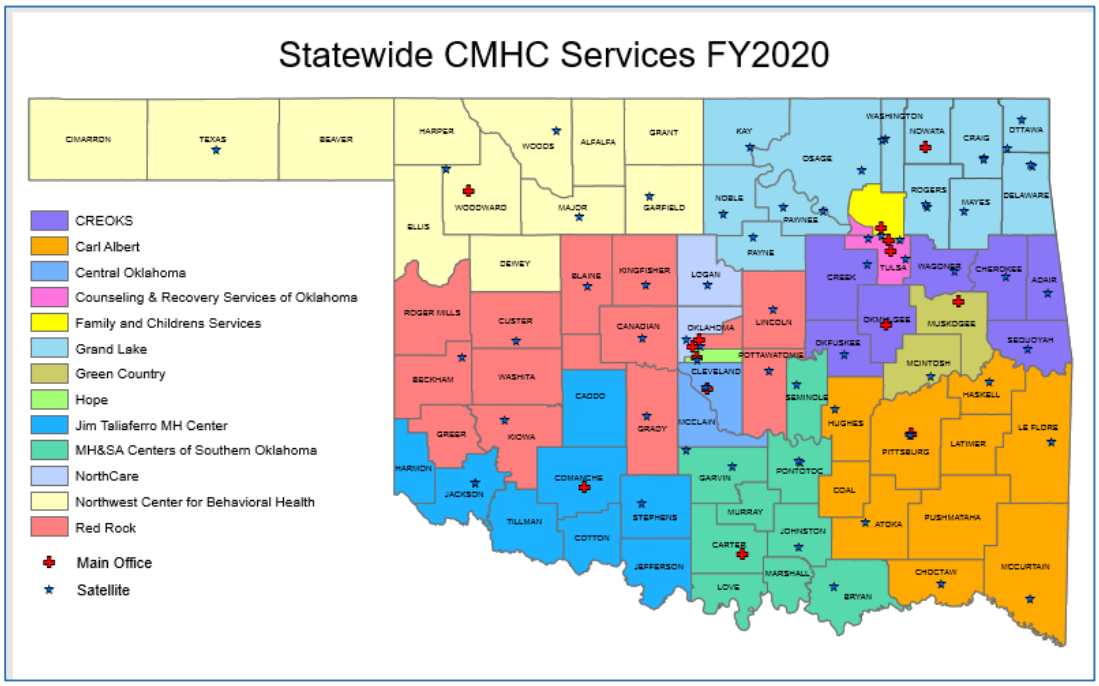
Services and supports are available statewide through a network of private and government-operated programs. These programs include 13 Community Mental Health Centers (CMHCs) and approximately 70 contracted substance use disorder treatment providers, including 11 Certified Community Addiction Recovery Centers (CCARCs). There are 21 Health Homes for adults with serious mental illness (SMI) and 20 Health Homes for children with serious emotional disturbance (SED) within the provider network; all CMHCs are certified as Health Homes. Health Homes are required to provide care coordination and care management to ensure integrated behavioral health and health care. In addition, there are two RA1SE NAVIGATE programs to assist individuals who are experiencing first episode of psychosis (FEP), along with one early serious mental illness (eSMI) crisis care program, and 13 statewide eSMI outreach programs provided through CMHCs. These programs develop and maintain collaborative partnerships with local higher education institutions and local hospitals to increase exposure to young adults within the age range that is most at risk for eSMI.

The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI. CMHCs served over 82,000 unique individuals in SFY 2019. CMHCs, by regulation, must provide crisis intervention, medication and psychiatric services, case management, evaluation and treatment planning, therapy services, and psychosocial rehabilitation. In addition, clients are provided with job location and placement, housing assistance, educational services, case management services, and other needed supports. All CMHCs also provide co-occurring and SUD treatment services.

The 13 CMHCs also participate in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local SOC sites that cover 72 counties. The SOC sites work in equal partnership with local teams and community organizations to ensure that children with SED and their families have access to the full array of services they need. The SOC initiative includes mobile crisis response and coordinated community response for children across most of the state, as well as community-based assessment to ensure children are placed in appropriate settings and supported in the community whenever possible. Community Based Structured Crisis Centers for children, located in Oklahoma City and Tulsa, address the emergent needs of children and their families.

In the adult system, CMHCs provide emergency assessments to individuals within their communities, largely via telehealth in rural areas. During this process, licensed behavioral health professionals (LBHPs) have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams. There are 11 Programs of Assertive Community Treatment (PACT), all of whom respond to their clients 24/7 (some leveraging technology such as iPads) to de-escalate crisis situations and help individuals maintain independence within their own home, in their own community. ODMHSAS data shows that the average number of inpatient days for CMHC clients has gone from 29.9 in SFY 2015 to 18.7 in SFY 2019.

There are nine crisis centers for adults located in the state. Currently, the State has only one facility-based crisis center with 16 or more beds; however, the State requests authority under this demonstration to include eligibility for Medicaid reimbursement for such facilities that qualify as IMDs. Crisis centers serve as an important component of the continuum of care, often preventing the need for inpatient admission and allowing for diversion of individuals in behavioral health crisis from emergency departments when clinically appropriate.



Oklahoma's SUD treatment and recovery services network currently provides services across the state and includes CMHCs and other ODMHSAS funded and/or Medicaid enrolled providers. The ODMHSAS funded services are primarily purchased through contracts with private, for-profit and non-profit, certified agencies to provide multiple levels of withdrawal management, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations. All SUD treatment organizations must be certified by ODMHSAS, with the exception of tribal entities located on land not subject to state jurisdiction. Facilities can be certified as a basic alcohol and drug treatment program providing a specific service set, an opioid treatment program, or as a Certified Comprehensive Addiction Recovery Center (CCARC) providing a full continuum of care, including intensive outpatient services. Currently, 11 CCARCs operate across 11 counties, with 26 site locations. Eighteen opioid treatment program locations cover 10 counties in the state.

The Oklahoma Department of Human Services (DHS) currently operates some congregate care facilities for children in state custody. The State plans to transition these facilities and their care model to serve as Qualified Residential Treatment Programs (QRTPs). The anticipated implementation date is October 1, 2021. As QRTPs are implemented, the State requests authority for Medicaid reimbursement of stays of 60 days or less in facilities that the State determines are IMDs.

Oklahoma's Need and Demand for Services

According to SAMHSA's 2017-2018 National Survey on Drug Use and Health (NSDUH), Oklahoma consistently has among the highest rates nationally for mental illness and substance use disorder. An estimated 20.43% of Oklahomans age 18 or older experience mental illness and 5.23% are estimated to have a serious mental illness. An estimated 8.54% of Oklahoma's population in that age group have a substance use disorder.[1]

Current Medicaid enrollee data for beneficiaries with identified SMI and SUD are provided below.

Medicaid beneficiaries with Identified SMI and SUD

Population	
Current Adult Medicaid Beneficiaries with identified SMI	62,979
Current Adult Medicaid Beneficiaries with Identified SUD	6,183
Current Medicaid Beneficiaries Under Age 18 with Identified SUD	639
Total	**69,801**

Individuals represented in the adult group include enrollees ages 18 and over in alignment with the availability assessment.

A 2016 study by the Commonwealth Fund found that Oklahoma had the eighth highest rate of deaths due to suicide, alcohol poising, or drug overdose. In 2016, methamphetamine became the primary drug of choice cited by those seeking ODMHSAS substance use treatment services. Similar to many states, opioid abuse has become a public health crisis in Oklahoma. Data from the NSDUH 2017-2018 report shows more than 4% of the population ages 12 and older is abusing/misusing painkillers, a rate higher than the national average.[2] A waiver of the IMD exclusion to expand SUD residential services will complement state efforts to combat these high rates.

Oklahomans continue to experience unmet needs for acute treatment of SMI and SUD, including waiting lists for inpatient and residential treatment. For residential treatment of substance abuse alone, recent data from ODMHSAS show that 158 women were on the waiting list (with an average wait time of 29 days to get into treatment) and 415 men were on the list (with an average wait time of 203 days to get into

[1]SAMHSA 2017-2018 National Survey on Drug Use and Health. Accessed from https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates.
[2] SAMHSA 2017-2018 National Survey on Drug Use and Health. Accessed from https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates

treatment). With additional funds appropriated through the Oklahoma Legislature in 2019, additional residential treatment beds are being added and are estimated to reduce waiting lists by 75%.

Numbers Served

In SFY 2019, 5,353 children under 21 and 2,078 adults ages 21-64 received Medicaid-funded inpatient psychiatric services. In that same year, 196,603 Oklahomans received outpatient and/or state-funded inpatient behavioral health services, of which 55.4% were individuals aged 18 or older. Over 33,000 of those individuals received services for substance abuse disorders; of those, nearly 30,000 were between the ages of 18 and 64. Nearly 18,000 of those adults had a co-occurring mental health and substance abuse diagnosis.

Opioid Epidemic

In 2012, Oklahoma had the fifth highest unintentional poisoning mortality rate in the United States (18.6 deaths per 100,000 population), which paralleled a significant increase in the dispensing of opioid pain relievers for non-cancer pain.[3] Opioid analgesics are involved in more unintentional poisoning deaths in the state than any other medication, representing 69.1% of all unintentional poisoning deaths associated with medications from 2007-2012.[4] Oklahoma is also one of the leading states in painkiller prescriptions per capita.[5] In 2017, Oklahoma providers wrote 88.1 opioid prescriptions for every 100 persons (a 30% decline since 2012, when the rate was 127 opioid prescriptions per 100 persons).[6]

Health Status and Health System Performance

According to the America's Health Rankings 2019 report, Oklahoma ranks 46th for overall health status. The State ranks 42nd in overall health behaviors, with continued high rates of physical inactivity, obesity, and smoking. Oklahoma ranks 32nd in clinical care overall, with a ranking of 44th for preventable hospitalizations. Additionally, the State ranks 47th in cancer deaths, 49th in cardiovascular deaths, 44th in premature death, and 43rd in frequent mental distress.[7]

The 2019 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance, with the state in the bottom quartile on access and affordability, avoidable hospital use and costs, healthy lives, and disparity.[8]

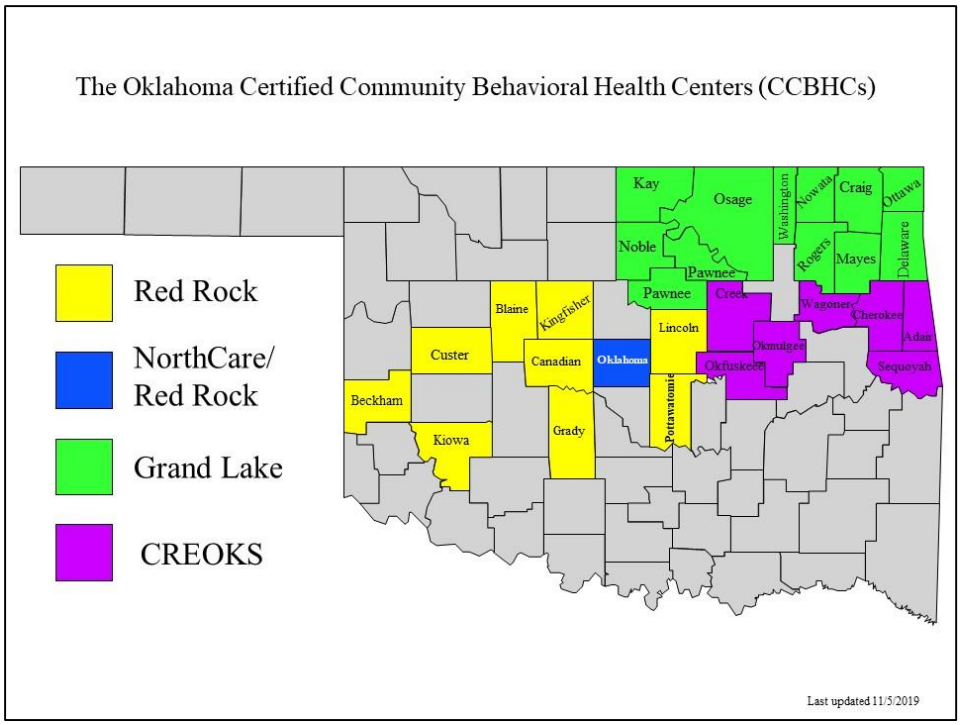
[3] Paulozzi L.J., Butnitz D.S., Xi Y. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiology and Drug Safety 2006;15:618-627.
[4] https://www.ok.gov/health2/documents/UP_Deaths_2007-2012.pdf
[5] Centers for Disease Control and Prevention. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. MMWR 2014;63
[6] CDC, US Opioid Prescribing Rate Maps. Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.
[7] America's Health Rankings. (2019). Retrieved from https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-oklahoma.
[8] Commonwealth Health Fund Score Card 2019 https://scorecard.commonwealthfund.org/state/oklahoma.

Oklahoma's Innovative Strategies

Certified Community Behavioral Health Clinics

In October 2016, Oklahoma was one of only eight states selected by SAMHSA and CMS to pilot Certified Community Behavioral Health Clinics (CCBHCs). The CCBHCs represented an opportunity for states to improve the behavioral health of their citizens by providing community-based mental health and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is an improvement over existing services. Participating CCBHCs must provide a broad array of services and care coordination across settings and providers on a full spectrum of health, including acute, chronic, and behavioral health needs. The CCBHC model also requires integrating mental health, substance use disorder, and physical health services at one location. Quality measures, which include screenings for body mass index, tobacco use, and unhealthy alcohol use and suicide risk assessments, are monitored by ODMHSAS.

There are four behavioral health clinics participating in this program, with site locations covering 29 counties. CCBHCs served over 35,000 unique individuals in SFY 2019. Initial data from the current three CCBHCs shows average inpatient days for CCBHC clients declined from 33.9 in SFY 2017 to 26 in SFY 2019. Further, for clients tracked previous to the launch of CCBHCs, data shows the average number of days inpatient was 43.2 in SFY 2016, demonstrating a significant decrease in the first fiscal year of CCBHC implementation.



Health Homes

Pursuant to a state plan amendment approved on February 10, 2015, Oklahoma implemented a Health Home service delivery model to improve care coordination and service integration, with the goal to improve health outcomes and control future health care costs for individuals with SMI or SED. Unique individuals served in Health Homes has risen from 16,530 in SFY 2016 to 25,544 in SFY 2019, with average inpatient days for Health Home clients decreasing from 42.3 to 22.2 in the same time period. Children with SED and adults with SMI are the most likely of all Oklahoma citizens to need inpatient psychiatric care, and people with SMI in Oklahoma die 25 years younger than the general population on average. Chronic health conditions are a large factor in these populations.

Health Homes focus on the integration of primary care, mental health services, and social services and supports for Medicaid-eligible adults diagnosed with SMI or children diagnosed with SED. The Health Home services model of care utilizes an interdisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals. The Health Home provides opportunities for Medicaid beneficiaries to receive services in their own home or community. Health Home services are designed to help connect people to medically appropriate services, and to help people remove barriers that keep them from effectively engaging with medically necessary services.

Crisis Care and Community-Based Assessments

A tiered support system is currently in place to ensure every effort is made to use inpatient and residential beds when clinically indicated and to support successful outcomes with outpatient services and community supports. ODMHSAS data show that 90% of urgent care clients are diverted from needing a crisis care bed; approximately 93% of individuals receiving crisis care do not move to a hospital bed; and approximately 95% of crisis care recipients are engaged with outpatient service follow-up within seven days of leaving crisis care.

Oklahoma utilizes a system of coordinated community response and mobile crisis response within the Systems of Care network to ensure children in crisis are connected with the appropriate level of care. Community-based assessments (CBAs) are completed by licensed behavioral health professionals (LBHPs) to ensure children in crisis are diverted from more restrictive inpatient settings if other community-based services are available to meet their needs. This system covers the majority of the state outside of the metropolitan areas, and Oklahoma is potentially pursuing expansion of this service to currently unserved areas. The CBA process involves a strong partnership between ODMHSAS and OHCA. CBA providers complete the assessment and work closely with OHCA to locate a proper placement for the child if medically necessary. Once placed in an inpatient setting, requests for extensions of care are provided to the CBA provider from OHCA. A determination from the CBA provider with a clinical rationale for denial or approval, as well as number of days if approved, is then given to OHCA within two hours.

The CMHCs have statewide coverage and are responsible for mental health crises in their service areas. In the adult system, CMHCs provide emergency assessments to their communities, largely via telehealth in rural communities. During this process, LBHPs have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams, with LMHPs connected 24/7 either in person or through telehealth in all but one. There are 11 programs of assertive community treatment (PACT), all of which respond to their clients 24/7 (some via iPads) to de-escalate crisis situations

and help individuals maintain in their own home in their own community. All but one is operated within a CMHC. Additionally, one CMHC that covers the northeastern corner of the state provides every client with an iPad that can be used for 24/7 emergent or non-emergent needs. This CMHC also provides iPads to law enforcement in its service area, allowing law enforcement to access a mental health professional without transporting the individual to a facility, reducing police transports and emergency room utilization. In addition, there are nine crisis centers for adults located in the state. Three more are planned for Oklahoma City within the next several years as part of a city improvement ballot initiative passed in December 2019.

Three CMHCs are part of the original CCBHC federal demonstration program, with current funding extended through November 2020. Additionally, a state plan amendment to move forward with new CCBHCs was approved by CMS June 4, 2019. One CMHC is certified to date, with two having active applications and one nearing application. ODMHSAS holds monthly technical assistance meetings to support and promote providers in transitioning to CCBHCs. Within the next two years, the State anticipates CCBHC implementation statewide. This model requires 24/7 mobile crisis response, as well as the ability for crisis response up to 23 hours and 59 minutes to stabilize every crisis possible and divert as many individuals as possible from the necessity of crisis center admissions and/or inpatient admissions.

Discharge Coordination

Efforts to promote successful transitions are integrated within ODMHSAS contractual requirements and administrative rules for providers. CMHCs and substance use disorder providers are contractually required to use the addiction severity index (ASI) or teen addiction severity index (TASI) at admission and discharge. Staff administering the ASI or TASI must be licensed behavioral health professionals and complete ASI training. Providers are also required to use American Society of Addiction Medicine (ASAM) criteria to determine level of care for consumer for admission, continued care, and discharge. Oklahoma also has developed a tool for providers to assess ASAM level of care, the Oklahoma Determination of ASAM Service Level (ODASL). Outpatient SUD providers are also required to offer case management to consumers discharging from withdrawal management or residential services within one week of discharge.

ODMHSAS operated hospitals serve as providers of short-term acute inpatient stabilization. These providers are required to complete discharge planning for continued treatment for co-occurring disorders and to communicate regularly with CMHCs and addiction recovery programs. CCBHCs are required by administrative rules to have contracts or memoranda of understanding with inpatient, residential, and medical withdrawal management facilities to ensure a formalized structure of transitional care planning. CCBHCs are further required to make reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge.

Inpatient psychiatric providers are required by state administrative rules to have a discharge plan for adults that documents the individual's hospitalization, recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, and a summary of the beneficiary's condition at discharge.

Efforts to Combat Opioid Use Disorder

State Opioid Response

A substantial challenge throughout Oklahoma is the lack of comprehensive access for opioid use disorder (OUD) services. This gap is intensified in the rural areas, in which 34% of the population of Oklahoma reside.[9] However, no county has adequate resources to address the current opioid epidemic. Many individuals with OUD have difficulty keeping and maintaining employment and housing without appropriate treatment, and there are major transportation barriers for rural communities. The cost of medications and other ancillary services that are provided with medication assisted treatment (MAT) can strain the already underfunded system. Additionally, many adults in the state are uninsured. In fact, Oklahoma ranks 49th for its rate of uninsured individuals, with 14.2% of the population without insurance coverage.[10] Those individuals who have private insurance are often unable to afford high deductibles. While Medicaid pays for MAT for women while they are pregnant, this coverage ends 60 days after birth, leaving these women without insurance to maintain services. However, should Medicaid expansion be implemented in the state, access to MAT and other outpatient SUD services for newly eligible adults will be significantly increased.

To combat opioid abuse, the ODMHSAS is focused on increasing access to MAT and reducing unmet needs and overdose related deaths through the provision of prevention, treatment, and recovery activities. In addition, the ODMHSAS also distributes naloxone kits and training has been provided to first responders, treatment agencies, and those in need.

Oklahoma has utilized the State Opioid Response (SOR) grant to support and expand efforts related to OUD prevention and treatment, including overdose education and naloxone distribution. From April 2019 to March 2020, ODMHSAS trained and provided naloxone to over 335 law enforcement officers in more than 100 agencies statewide and provided more than 3,000 replacement kits to agencies previously trained in naloxone administration; another 8,400 individuals were equipped through expanded prevention hubs, of which there are 70 in the state. More than 1,400 kits were distributed to schools, youth-serving organizations, and individuals specifically to protect youth 19 and under through a partnership with the OHCA and through Title XXI Health Service Initiative funding.

Continued partnerships with pharmacies and community-based agencies throughout the state have promoted the availability of general public access to naloxone medication and overdose prevention education. Additionally, community coalitions have directly engaged over 52,000 Oklahomans and made nearly 10,000 referrals to treatment and overdose prevention services, with just under 4,400 Oklahomans receiving direct treatment and recovery services through the grant. ODMHSAS also contracted to make available A-CHESS (Addiction Comprehensive Health Enhancement Support System), a relapse prevention program administered through a smartphone application. This application has multiple uses, including making automatic consented referrals to a referring partnering agency, giving the authority of the agency to contact the individual in need.

[9] United States Census Bureau. (2010). Decennial census, urban and rural. Retrieved from https://data.census.gov/.

[10] America's Health Rankings. (2019). Retrieved from https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-oklahoma.

Enhancement of provider skills and knowledge is also a part of these efforts. Cognitive behavior therapy (CBT) training has been provided by ODMHSAS and all CMHCs employ clinical staff trained in CBT. ODMHSAS also trains and certifies peer recovery support specialists (PRSS). SOR efforts have included expansion of MAT through telehealth and throughout a statewide network of CMHCs and Comprehensive Community Addiction Centers (CCARCs), as current availability to MAT in residential treatment settings is a challenge for the state. Under this demonstration, the State will require all Medicaid-enrolled residential SUD providers to provide MAT or have a relationship with a MAT provider to ensure access to medication for the individuals they serve.

The ODMHSAS has also increased access to services through telemedicine. Thus far, Oklahoma is recognized as the first state to do induction via telehealth for buprenorphine. The State has several agencies in rural areas that are now providing this service. Due the lack of waivered prescribers that are actively prescribing, it is difficult for some individuals to receive this service without telehealth.

Practice Facilitation

The OHCA has partnered with a third-party vendor (Telligen) to conduct targeted practice facilitation of SoonerCare Patient Centered Medical Home (PCMH) providers. The practice facilitators, who are trained in pain management, work with providers over a six-month period to improve patient care management. The areas addressed include:

- How to conduct initial patient assessments for chronic pain and risk of opioid dependence;
- Methods for monitoring medication use, including conducting urine drug screenings at each visit;
- Alternative pain management techniques that can be offered to patients; and
- Assistance in making patient referrals to physician pain management specialists.

The OHCA has targeted the program to providers with high opioid prescribing patterns. The program began in January 2016. Since that time, approximately 100 practices have undergone the six-month practice facilitation intervention.

The OHCA also recently expanded Telligen's pain management activities under a new contract that took effect in July 2019. Pursuant to the new contract, Telligen will be offering pain management practice facilitation to PCMH sites undergoing broader practice facilitation for management of patients with chronic medical and/or behavioral health conditions. This is in addition to continuing targeted practice facilitation of high prescribers.

The OHCA has also reduced barriers to MAT by eliminating refill limits through a state plan amendment. A planned future state plan amendment this calendar year will provide coverage of methadone for MAT.

Prescription Monitoring Program

The Oklahoma Prescription Monitoring Program (PMP) is authorized under state law to collect controlled drug prescription information from dispensers. The Oklahoma PMP is operated by the Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBN) while working closely with the Governor's Office, ODMHSAS, the Department of Health, the Medical Examiner's Office, and the OHCA to identify issues impacting the health and safety of Oklahomans. The Oklahoma PMP is widely recognized as one of the most respected and advanced systems in the country. As part of OBN, the Oklahoma PMP pioneered

electronic PMP databases, real-time reporting, HIE integration, standard PMP best practices, interstate data sharing standards, and advisory committees.

The Oklahoma PMP requires dispensers of controlled substances to submit prescription information within five minutes of dispensing a scheduled narcotic. The PMP can serve a multitude of functions including assisting in patient care, provide early warning of drug abuse epidemics (especially when combined with other data), evaluating interventions, and investigating drug diversion and insurance fraud. In accordance with state law, the ODMHSAS receives PMP data and has utilized data for epidemiological risk assessments, planning overdose prevention and primary care practice improvement programs, and informing state and community-level opioid prevention and treatment efforts. The ODMHSAS has partnered with the OHCA and the State Department of Health on collaborative efforts to strategically utilize PMP data for prescriber, dispenser, and patient education. The agencies convene an ad hoc PMP advisory committee to solve problems, share information, plan partnership projects, and discuss system needs or enhancements.

Provider Qualifications and Service Utilization

OHCA and ODMHSAS understand the importance of maintaining quality assurance with providers serving beneficiaries, including mechanisms to support individuals accessing services consistent with level of care needs in a timely manner. As such, the State currently has in place certification requirements aligned with best practices, including utilization of ASAM program criteria across SUD levels of care. Additional behavioral health provider requirements also provide assurances that beneficiaries are being supported during transitions in care, including care coordination and continuity of the treatment plan between acute care and outpatient providers.

Provider Certification

Certification of psychiatric hospitals and psychiatric units of general hospitals will continue to leverage current requirements, which include either a successful state survey to meet requirements for a Medicare psychiatric hospital or a national accreditation recognized by CMS for psychiatric hospitals in accordance with Oklahoma Administrative Code (OAC) 317:30-5-95.

All SUD treatment organizations must currently be state certified by ODMHSAS, with the exception of tribal entities located on land not subject to state jurisdiction. Facilities can be certified as a basic alcohol and drug treatment program providing a specific service set or as a Certified Comprehensive Addiction Recovery Center (CCARC). Under this demonstration, all Medicaid-enrolled residential SUD providers will be required to have accreditation by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). Additionally, the state plans to pursue the implementation of a certificate of need (CON) process, or similar process, for the addition of new residential SUD providers entering the network. A CON process is currently in place for inpatient psychiatric beds under the authority of the Oklahoma State Department of Health.

Community-Based Structured Crisis Centers must be certified by ODMHSAS in accordance with OAC 450:23. While there is currently only one crisis center that qualifies as an IMD in the state, the State seeks authorization under this waiver to include additional facilities in the Medicaid program should they become available in response to the State's needs. It is anticipated that some providers will be willing to increase capacity if there is continued access to Medicaid reimbursement. The State's current system

limits crisis facilities to CMHCs, CCARCs, or state-operated facilities, and as such the ODMHSAS will monitor needs for additional beds or providers.

Oklahoma anticipates implementation of QRTPs on October 1, 2021. All QRTPs will be licensed by the Oklahoma DHS. To qualify as a QRTP, in accordance with Title IV-E federal requirements, the program must be licensed and nationally accredited by CARF, the Joint Commission, or COA.

Prior Authorization, Medical Necessity Criteria, and Length of Stay

Prior authorization for services authorized within the waiver will be completed by OHCA or its designated behavioral health utilization management organization. Prior authorization will be required for all newly eligible inpatient stays for adults authorized within this waiver through a process developed by ODMHSAS in partnership with OHCA. Facility-based crisis services are currently authorized by ODMHSAS through an instant prior authorization process. Residential SUD services will be prior authorized through a collaborative process developed by ODMHSAS and OHCA, utilizing the submission of an ASAM level of care assessment tool by the outpatient provider. The State plans to utilize assessment tools such as the Child and Adolescent Needs and Strengths assessment to identify children appropriate for placement in a QRTP.

Oklahoma will aim for a statewide average length of stay for inpatient treatment and residential treatment of 30 days. Length of stay extensions will be authorized on a case by case basis and according to medical necessity and practice guidelines.

III. DEMONSTRATION GOALS AND OBJECTIVES

Through this demonstration, Oklahoma seeks to support the overall health and long-term successful outcomes of individuals with SMI and SUD. The overarching premise this demonstration supports is that, if the full continuum of care is provided, individuals who access the system will receive the least restrictive, most effective provision of services, which is continually evaluated so that individuals' changing needs translate to changing services to meet those needs.

The State's goals as identified below align with CMS guidance given related to demonstration authority for SUD (SMD #17-003) and SMI/SED (SMD #18-011).

SUD Goals

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Hypotheses and Evaluation Plan

Based on the goals identified above through CMS guidance, Oklahoma proposes the following evaluation plan. This approach has been developed in alignment with CMS evaluation design guidance for SUD and SMI 1115 demonstrations. The State will contract with an independent evaluator to conduct this review.

Substance Use Disorder

Objective/Goal	**Hypothesis**	**Evaluation Parameters/Methodology**
Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?		
GOAL 1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	**Hypothesis 1.** The demonstration will increase the percentage of beneficiaries who are referred to and engage in treatment for OUD and other SUDs.	**Data Sources:** • Claims data • Provider survey • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 2. Increased adherence to and retention in treatment for OUD and other SUDs.	**Hypothesis 2.** The demonstration will increase the percentage of beneficiaries who adhere to treatment of OUD and other SUDs.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance • T-Test

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 3. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	**Hypothesis 3.** The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	**Data Sources:** • Claims data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Do enrollees receiving SUD services experience improved health outcomes?		
GOAL 4. Improved access to care for physical health conditions among beneficiaries.	**Hypothesis 4.** The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.	**Data Sources:** • Claims data • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.	**Hypothesis 5.** Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?		
GOAL 6. Reduction in overdose death, particularly those due to opioids.	**Hypothesis 6**. The demonstration will decrease the rate of overdose deaths due to opioids.	**Data Sources:** • Claims data • Administrative data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance

Serious Mental Illness

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings? How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?		
GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.	**Hypothesis 1.** The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.	**Data Sources:** • Claims data • Medical records or administrative records • Interviews or focus groups **Analytic Approach:** • Difference-in-differences model • Subgroup analyses • Descriptive quantitative analysis • Qualitative analysis
Evaluation Question: Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings? How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?		
GOAL 2. Reduced preventable readmissions to acute care hospitals and residential settings.	**Hypothesis 2.** The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	**Data Sources:** • Claims data • Medical records • Beneficiary survey **Analytic Approach:** • Difference-in-difference models • Qualitative analysis • Descriptive quantitative analysis

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state? To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?		
GOAL 3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs; psychiatric hospitals; and residential treatment settings throughout the state.	**Hypothesis 3.** The demonstration will result in improved availability of crisis stabilization services throughout the state.	**Data Sources:** • Annual assessments of availability of mental health services • AHRF data • NMHSS survey • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis
Evaluation Questions: Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health needs? To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED? To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services? How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics? Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED improve under the demonstration?		
GOAL 4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care.	**Hypothesis 4.** Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	**Data Sources:** • Claims data • Annual assessments of availability of mental health services • AHRF • NMHSS survey • Administrative data • URS • Medical records **Analytic Approach:** • Descriptive quantitative analysis • Chi squared analysis • Difference-in-differences model

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: Does the demonstration result in improved care coordination for beneficiaries with SMI/SED? Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities? How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?		
GOAL 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Hypothesis 5.** The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Data Sources:** • Claims data • Medical records • Interviews or focus groups • Facility records **Analytic Approach:** • Difference-in-differences model • Descriptive quantitative analysis • Qualitative analysis

IV. IMPACT ON ENROLLMENT, BENEFITS, COST SHARING, AND DELIVERY SYSTEM

Demonstration Eligibility

All enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21-64, will be eligible for services under the waiver, subject to medical necessity criteria. Additionally, Medicaid enrollees under the age of 21 may qualify for services under the waiver when receiving residential SUD or QRTP services. Only the eligibility groups outlined in the table below will not be eligible for these services as they receive limited Medicaid benefits only.

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR § 435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Soon-to-be-Sooners (STBS/Unborn Child)	2111(b)(4)
Family Planning*	1902(a)(10)(A)(ii)(XXI)

*Note: The Family Planning limited benefit program will be eliminated if Medicaid expansion is implemented in the future, as eligible individuals will be transitioned as newly eligible adults into the full scope Medicaid program.

Enrollment

SoonerCare currently covers approximately 785,000 total individuals within all programs. Medicaid expansion starting July 1, 2021, if passed by voters, will likely add a significant number of newly eligible adults to Medicaid enrollment. This 1115 waiver is not anticipated to impact SoonerCare enrollment over the course of the five-year demonstration, as there are no waiver-specific eligibility criteria included.

Benefits

Current Medicaid beneficiaries have access to a robust behavioral health service system. This demonstration seeks to enhance the continuum of care by adding inpatient, residential substance use disorder, and facility-based crisis stabilization services furnished at an IMD to the Medicaid service system. This enhancement will promote the use of the most effective, appropriate services to support long-term successful outcomes. Specific services in the current and future Medicaid system are provided in Appendix A.

Cost Sharing

This waiver will not impact or add any cost sharing requirements. Currently, the State's Medicaid program includes co-pays for non-exempt individuals covered under Title XIX. Adults are subject to inpatient copays, which are currently $10/day (up to $75 max). Cost sharing has a cap of 5% of the aggregate household income. This cap is based on the household's total gross income and is applied monthly; once the household reaches their 5% cap in a month, no additional cost sharing is assessed in that month. Individuals exempt from copays include pregnant women and individuals who are American Indian/Native American.

Delivery System

This waiver will not change the Medicaid delivery system. The State's Healthy Adult Opportunity (HAO) 1115 waiver application is currently undergoing federal public comment. The HAO application seeks to add newly eligible adults, ages 19-64, who have incomes at or below 133% of the federal poverty level (FPL) and requests authorization for delivery system changes that focus on care coordination, behavioral health integration, and value-based payment methodologies for providers. Should the application be approved, the additional benefits this SMI/SUD waiver seeks authorization to add to the Medicaid service array will be included in these delivery system changes.

Payment Rates for Services

Payment methodologies will be consistent with those approved in the Medicaid State Plan, where applicable. Inpatient and residential IMD services will be reimbursed via a per diem methodology, with crisis stabilization reimbursed through an hourly payment structure. Providers will also receive separate payments for certain services and benefits, as applicable and in accordance with the Medicaid State Plan. Such payments will include, but not be limited to, payment for MAT medications provided under arrangement.

Under the authority of this waiver, the State seeks to promote the outcomes and goals of the demonstration through the implementation of a value-based payment structure for all Medicaid-enrolled residential SUD providers. The State plans to implement a system whereby these providers must meet certain quality benchmarks in order to receive a 10% bonus to their per diem rate. The State seeks flexibility to modify the parameters of this payment structure throughout the demonstration period in order make improvements as experience is gained and outcomes data is collected.

V. WAIVER IMPLEMENTATION

This waiver will be implemented statewide, with a requested effective date of October 1, 2020. The State requests a five-year waiver approval for this demonstration.

VI. LIST OF PROPOSED WAIVERS AND WAIVER ELIGIBILITY

Oklahoma seeks expenditure authority under Section 1115(a) for services provided to otherwise eligible individuals under age 21 in QRTPs and for residential substance use disorder stays. Additionally, the State seeks expenditure authority for short-term inpatient stays, residential substance use disorder stays, and facility-based crisis stabilization stays in facilities that qualify as IMDs for enrollees ages 21-64. Additional services listed in Appendix A will be added through future state plan amendments.

This demonstration will include all eligible individuals ages 21-64 (and under 21 where applicable) who are eligible for Medicaid and does not impose any additional eligibility criteria.

VII. FINANCING AND BUDGET NEUTRALITY

Budget Neutrality Overview

Oklahoma is seeking Section 1115 demonstration authority to offer a full continuum of services for adults requiring treatment for a serious mental illness (SMI), adults in need of substance use disorder (SUD) treatment and adolescents in need of SUD treatment.

Oklahoma prepared its budget neutrality model in accordance with CMS guidelines. The CMS IMD Budget Neutrality Template provides states with two scenarios for establishing "costs not otherwise matchable" or CNOM limits. The State developed per capita limits based on Scenario 1, which is limited to expenditures for otherwise covered services to otherwise eligible members who primarily are receiving treatment for SMI or SUD in an IMD. The completed CMS template for IMD waivers is included as Appendix B.

Oklahoma proposes three Medicaid eligibility groups (MEGs) for the demonstration, as follows:[11]

- MEG 1: Adult SMI, Ages 21 to 64
- MEG 2: Adult SUD, Ages 18 to 64
- MEG 3: Adolescent SUD, Ages 17 and Under

[11] The state's intent was to include crisis stabilization for individuals 18-64 due to recent guidance regarding the "Psych under 21" benefit limitation. However, per CMS guidance that, because the waiver narrative did not specify this coverage for individuals age 18-20, the state would have had to re-post the waiver for public comment, the state updated the MEGs to reflect ages 21-64.

Data Source

Data was extracted from the Oklahoma Medicaid Management Information System, including Department of Mental Health and Substance Abuse Services (DMHSAS) utilization data (funded by State-only dollars), member demographic information, Medicaid eligibility data and Medicaid expenditure data. Oklahoma established Calendar Year 2019 as its base year.

Development of Base Year Utilization and Expenditure Data

Identification of Medicaid Eligibles and MEG Assignment

Utilization data was used to identify inpatient and residential services for the treatment of SMI and SUD diagnoses. Inpatient and residential stays for the treatment of SMI that were over 60 days were removed. Individuals receiving the identified inpatient and residential services then were aligned with Medicaid eligibility data to identify members who were enrolled with Medicaid at the time of their stays. Individuals' ages were determined as of the admission date.

Development of IMD Expenditure Estimates

Total IMD expenditures are equal to the product of IMD utilization (days) and established payment rates. The reimbursement rates to do not include compensation for room and board.

As part of the demonstration, the State intends to offer performance-based bonus payments to promote the goals and outcomes of the demonstration. The State will make bonus payments available to SUD residential providers, up to a maximum of 10 percent of fee-for-service per diem payments. For purposes of estimating total IMD expenditures, the State estimates that 80 percent of bonus payments will be distributed. The established rates for SUD services were adjusted upward by eight percent (10 percent of FFS payment rates x 80 percent of available bonus payments).

Calculation of Medicaid Member Months

Member months were determined based on the whole month where Medicaid members were IMD patients for at least one day during the month. For example, if a member received treatment in an IMD from May 24 through June 2, two member months were included in the historical caseload totals.

Medicaid Expenditure Data

The State identified all Medicaid expenditures for the whole months in which individuals were patients for at least one day in an IMD.

Development of Base Year Per Member Per Month (PMPM) Costs

The table below presents a summary of base year (Calendar Year 2019) PMPM costs for each of the proposed MEGs.

	IMD Services MEG 1: SMI Adults, Ages 21 to 64	IMD Services MEG 2: SUD Adults, Ages 18 to 64	IMD Services MEG 3: SUD Adolescents, Ages 17 and Under
Expenditures	$6,335,957	$13,706,377	$928,996
Member Months	676	3,292	241
Base Year Per Member Per Month (PMPM) Costs	$9,373	$4,164	$3,855

Development of Enrollment and Expenditure Projections

Enrollment Estimates

The base year PMPMs are derived solely from data for members who were enrolled with Medicaid for qualifying IMD stays within the base year (Calendar Year 2019).

For purposes of projecting future caseload, Oklahoma established an annual caseload trend rate of six percent. This trend rate reflects the State's estimate of projected annual growth in participation under the IMD demonstration, considering economic factors and their impact on Medicaid eligibility, enhanced access to services for SMI and SUD treatment and population health needs.

Per Member Per Month (PMPM) Trend Rate

Oklahoma applied an annual trend rate to the Calendar Year 2019 base year PMPM equal to 4.8 percent. This trend rate represents the President's Budget trend rate for the Medicaid expansion population.

Budget Neutrality Summary

Oklahoma's proposed IMD demonstration will be budget neutral in accordance with Section 1115 requirements. The table below provides a summary of program expenditures without and with the Demonstration, over the five-year waiver period.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$7,616,048	$8,460,516	$9,398,618	$10,440,740	$11,598,408	$47,514,331
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$16,475,564	$18,302,381	$20,331,742	$22,586,107	$25,090,451	$102,786,245
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
TOTAL	$25,208,298	$28,003,402	$31,108,413	$34,557,697	$38,389,448	$157,267,259

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$7,616,048	$8,460,516	$9,398,618	$10,440,740	$11,598,408	$47,514,331
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$16,475,564	$18,302,381	$20,331,742	$22,586,107	$25,090,451	$102,786,245
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
TOTAL	$25,208,298	$28,003,402	$31,108,413	$34,557,697	$38,389,448	$157,267,259

Net Overspend	$0	$0	$0	$0	$0	**$0**

CMS Budget Neutrality Template for IMD Demonstrations

The completed CMS Budget Neutrality template is provided in Appendix B and includes the following tables:

- IMD Overview
- IMD Historical
- IMD Without Waiver
- IMD With Waiver
- IMD Summary
- IMD Caseloads

Maintenance of Effort

In accordance with the November 13, 2018, CMS State Medicaid Director Letter, the State understands this waiver request is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions.

The following table details the SFY 2019 outpatient community-based behavioral health expenditures.

Expenditures on Outpatient Community-Based Behavioral Health Services (in Millions)

Medicaid Program	Total Dollars	Federal Dollars	State Dollars
Regular Title XIX	$157.0	$96.5	$60.5
CHIP	$35.5	$34.1	$1.4
Health Home	$34.3	$21.0	$13.3
CCBHC	$57.1	$41.8	$15.3
Total	**$283.9**	**$193.4**	**$90.5**

Oklahoma is dedicated to maintaining access to community-based services and intends for services authorized within this waiver to complement but not replace these outpatient services. However, we offer the following caveats as considerations for measuring maintenance of effort based strictly on total expenditures:

- Unpredictable state budgets, particularly in consideration of the COVID-19 emergency, may impact the amount of state funding available for services.
- The State may pursue programmatic changes to the Medicaid program, including but not limited to a Medicaid expansion state plan amendment, a Healthy Adult Opportunity waiver, and/or a waiver amendment to include newly eligible individuals in the Patient Centered Medical Home (PCMH). Programmatic changes such as these may impact the number of covered lives and increase health system efficiencies, which will impact expenditures.

VIII. STAKEHOLDER ENGAGEMENT AND PUBLIC NOTICE

Public Notice

The State conducted public notice in accordance with 42 CFR §431.408. OHCA held two virtual public hearings on this proposal as follows:

Virtual Public Hearing
May 6, 2020, at 3 p.m.

Virtual Public Hearing
May 8, 2020, at 3 p.m.

Interested persons were encouraged to visit www.okhca.org/PolicyBlog to view a copy of the proposed waiver, public notice(s), location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates. Due to the current public health emergency and the

associated social distancing guidelines, persons wishing to present their views in writing or obtain copies of the proposed waiver could do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver were accepted by contacting OHCA as indicated. Comments submitted through the OHCA policy blog were available for review online at www.okhca.org/PolicyBlog. Other written comments were available upon request at federal.authorities@okhca.org. Comments were accepted May 1-31, 2020. After expiration of the comment period, the proposed draft application was removed from the policy public comment blog and placed in the archive of proposed policy changes at http://okhca.org/providers.aspx?id=12395.The State made revisions to the waiver application narrative, budget neutrality figures, enrollment projections, and supplemental documentation that was originally posted online prior to official submission to CMS on June 8, 2020 to remove Medicaid expansion assumptions as the State is no longer promulgating state plan amendments (SPAs) to expand Medicaid with a requested effective date of July 1, 2020. The State officially withdrew its SPA proposal on May 28, 2020. The State will have a ballot measure to expand Medicaid, via a State Plan Amendment, on the June 30, 2020 ballot and has an active Healthy Adult Opportunity waiver application submission. The aforementioned pending measures may impact the eligible populations, budget neutrality figures, enrollment numbers, and/or information presented within the proposed IMD waiver application.

Tribal Consultation

Due to social distancing guidelines and recommendations during the current public health emergency (PHE), COVID-19, tribal consultation was held April 1, 2020, by the Oklahoma Health Care Authority (OHCA) via a virtual meeting. Twelve tribal representatives and 18 OHCA staff were on the call. There was one comment received during the virtual consultation in reference to the IMD waiver. During consultation, a tribal partner expressed interest in further discussion on assessing residential treatment services. OHCA agreed to further discussion and met with interested tribal partners on May 13, 2020. Based on the feedback received from tribal partners during these targeted meetings, the State added in its IMD waiver application that certain tribal facilities located on land not subject to state jurisdiction would not be required to have additional ODMHSAS certification to participate as a SUD provider.

Public Hearings

In light of the COVID-19 public health emergency, the CDC's social distancing guidelines, Oklahoma executive orders (2020-07 and 2020-08) as well as the federal authority provided to states at 42 CFR 431.416(g)(ii), Oklahoma engaged in a virtual public comment process rather than the traditional process for seeking the public's input on new 1115 waiver demonstration applications. The State sent out web alerts to email addresses on file of the posting of the full waiver to garner public input, leveraged its social media platforms (Facebook and Twitter), facilitated workgroups with tribal partners, and conducted two public virtual hearings/meetings.

The two virtual public hearings were held on May 6, 2020 and May 8, 2020; 42 stakeholders were in attendance. There were three comments received during the first public hearing for the IMD waiver. One commenter inquired about the impact on PRTFs and RTCs. Presenters responded that they would not be impacted by the waiver, as they are providers currently eligible to receive Medicaid reimbursement and serve children and adolescents. Another question inquired about whether the State had concerns about CMS' approval of a joint SMI/SUD waiver. The presenters replied that there were no concerns based on

guidance received by the State. A third hearing participant asked if new residential SUD providers would be able to enroll. The presenters replied that new providers would be able to enroll with Medicaid, provided they meet requirements that include a process similar to certificate of need (CON) for new providers and beds.

Two comments were received at the virtual public hearing held on May 8, 2020. One commenter inquired about estimates on the number of beneficiaries receiving SUD residential treatment. Presenters responded that there are estimates for current and newly eligible beneficiaries in the waiver application based on prevalence rates. The second question was related to which providers are included in the CON process. Presenters clarified that the current CON process for inpatient beds will continue, but a new process is being proposed for residential SUD providers.

Public Comment Period

Public comments were accepted from May 1-May 31, 2020. Two written comments were received. One comment noted general support for the waiver application. A second written comment noted several concerns regarding the lack of content pertaining to the utilization of private hospitals to support the goals of the waiver. The State provided a response noting that private hospital IMDs would be included under the waiver and explained the reasoning for the utilization of crisis stabilization services for adults in certain circumstances.

Appendix A: Current and Proposed Future SoonerCare Behavioral Health Benefits

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	1115 IMD
ASAM Level 0.5: Prevention					
Alcohol/Drug Screening	Other Lic. Pract.	3a-1a	QBHT; CPSP		
Primary Care Screening (SBIRT)	Physician		Physician		
OP SA Preventive Counseling	EPSDT	1a-6.6	BHP; QBHT		
Evaluation and Management (Tobacco Cessation)	Physician	2a-2	Physician		
SMI/SED Outpatient & ASAM Level 1: Outpatient					
Alcohol/Drug Assessment.	Other Lic. Pract.; Rehab	3a-1a; 6a-1.2; 1a-6.5	Level 2 BHP		
Medication Management	Physician	2a-2	Physician		
Psychiatric DX Assessment	Physician	2a-2	Psychiatrist		
Psychological Testing	Rehab; EPSDT	6a-1.3	Psychologist BHP		
Licensed Behavioral Health Practitioner Services	EPSDT	1a-6.1	Clinical Psychologist or BHP elig. to practice independently		
Treatment Planning	Rehab; EPSDT	6a-1.2; 6a-1.6 (PACT); 6a-1.14 (CCBH); 1a-6.5	Level 1 or Level 2 BHP		
Psychotherapy: Individual, Family, Group	Rehab; EPSDT	6a.1.2; 6a-1.6a (PACT); 6a-1.14 (CCBH)	Level 1 or Level 2 BHP		
Medication Training & Support	Rehab	6a-1.3; 6a-1.6 (PACT); 6a-1.15 (CCBH)	RN		
Psychosocial Rehab (PSR); Ind., Group	Rehab	6a-1.3; 6a-1.6a; 1a-6.5a	QBHT under supervision of BHP		
PSR, Children	EPSDT	1a-6.5a-5b	QBHT under supervision of BHP		

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	1115 IMD
ASAM Level 1: Outpatient (Con't)					
Intensive Family Intervention	EPSDT	1a -6.5a	BHP		
Intensive in-home Services	EPSDT	1a -6.5a	QBHT under supervision of BHP		
Therapeutic Day Treatment	EPSDT	1a -6.5c	QBHT under supervision of BHP		
Therapeutic Behavioral Services	EPSDT	1a -6.5b	QBHA under supervision of BHP		
Multi Systemic Therapy	EPSDT	1a -6.5c	BHP, QBHT (Team)		
Peer/Family Support	Rehab; EPSDT	6a-1.2a; 6a-1.6a (PACT); 6a-1.16 (CCBH); 1a- 6.5b	CPSP		
Co-Occurring Treatment for SA	Rehab (PACT)	6a-1.6a	Appropriately licensed, registered or certified provider		
Psychoeducation and Counseling	Rehab	6a-1.15 (CCBH)	Nurse or Dietitian		
Health Promotion/Wellness	Rehab (PACT)	6a-1.6	Any Qualified Team member		
Case Management, (Incl. drug court) Targeted Case Management Transitional CM	Case Management TCM	Supp to Att. 3.1-A, Pages 1b-1g	QBHT		
Care Coordination	Rehab (CCBH); (PACT)	6a-1.6; 6a-1.14	Team BHP, RN, LPN, QBHT, CPSP		
Health Home	Health Home SPA		Health Home Team		
CCBH Services	Rehab	6a-1.10	CCBH Team		
SMI/SED & ASAM Level 2: Intensive Outpatient/ Partial Hospitalization					
Intensive Outpatient/SA, Adolescent (ASAM 2.1)	EPSDT	1a -6.5c	BHP or CADC		
Intensive Outpatient, Adult (ASAM 2.1)	Rehab, TCM	See Notes	BHP or CADC		
Partial Hospitalization, Adolescent (ASAM 2.5)	EPSDT OP Hosp	1a-6.5e 1a-2	Clinical Team BHP, RN, QBHT		
Partial Hospitalization, Adult (ASAM 2.5)			Clinical Team BHP, RN, QBHT	X	

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	1115 IMD
Medication Assisted Treatment					
Suboxone® (buprenorphine/ naloxone SL films), Vivitrol	Prescription Drugs	5a-1	Pharmacy	Adding Methadone	
SMI/SED & ASAM Level: 3.1, 3.3, 3.5, 3.7 Residential / Inpatient					
Clinically Managed Low Intensity Residential (ASAM Level 3.1) for Adults and Adolescents in RTF					X
Clinically Managed Population-Specific, High Intensity Svcs. (ASAM Level 3.3) for Adults in RTF					X
Clinically Managed Medium Intensity for Adolescents and Clinically Managed High Intensity for Adults (ASAM Level 3.5)					X
Medically Monitored High Intensity Inpatient Withdrawal Management (ASAM Level 3.7) for Adults and Adolescents in RTF					X
Qualified Residential Treatment Programs (QRTP)					X
Psychiatric Residential Treatment Facility (PRTF)	IP Psych Services	7a-2	Accredited PRTF		
SMI/SED Crisis Services					
Crisis Intervention Services	Rehab; EPSDT	6a-1.3; 6a-1.6a (PACT); 6a 1.14 (CCBH); 1a-6.5	BHP		
Crisis Psychotherapy, Mobile	Rehab; EPSDT	6a-1.6a (PACT); 6A-1.14 (CCBH) 1a-6.5	Team BHP & QBHT or CPSP		
Facility Based Crisis Stabilization (<16 beds)	Rehab; EPSDT	6a-1.3 1a-6.5	BHP		
Urgent Recovery Center Services	Clinic	4a-1.4	Level 1 or Level 2 BHP		
Crisis Stabilization, >16 beds					X

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	1115 IMD
Acute Psychiatric and ASAM Level 4: Inpatient					
Clinically Managed Intensive Inpatient (ASAM Level 4)/Acute Psychiatric for Adolescents in Lic. General Hospital or Lic. Psychiatric Hospital; Adults in Lic. General Hospital	IP Hospital Svcs.; IP Psych Svcs.; EPSDT	1a-1; 7a-2; 1a-6.6			
Clinically Managed Intensive Inpatient (ASAM Level 4)/Acute Psychiatric for Adults in Lic. Psychiatric Hospital/IMD					X

Notes: Ambulatory detox services are not covered as a discrete service model for adults but are routinely provided concurrently with other addiction services, by the same clinical staff, and in the same treatment setting.

Intensive outpatient services are not covered as a discrete service model for adults but can be reimbursed through the provision of a combination of services, including psychotherapy, targeted case management, and psychosocial rehabilitation.

Outpatient coverage includes delivery of telemedicine for applicable services.

Appendix B: CMS Budget Neutrality Worksheets

IMD Overview

How To Use This Spreadsheet:

Consult the tables below for a overview of the "IMD Services Limit" and "Non-IMD Services CNOM Limit" in Scenarios 1 and 2. The tables provide basic concepts and frameworks for establishing the budget neutrality limits--and expenditure reporting requirements for monitoring. The notes below the table provide additional information related to allowable IMD medical assistance services, estimation of the various budget neutrality limits, trend rates, "in lieu of" services and other details of estimation and expenditure reporting. For states proposing to include IMD services as a component of their broader 1115 demonstrations, the limits established in this spreadsheet--once approved by CMS--will be included in the comprehensive budget neutrality spreadsheet, STCs and expenditure monitoring tool (see State Medicaid Director Letter #18-009). The limits established may be used as an upper limit for all medical assistance services provided in an IMD--or separately tabulated by, for example, diagnosis-type (see glossary below for definition of abbreviations).

Scenario 1

Situation: Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD, SMI and/or SED who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA).	IMD Services Limit	Non-IMD Services CNOM Limit
Without Waiver (i.e., budget neutrality limit)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day BN Expenditure Limit · PMPM cost × IMD MMs	
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	

Appendix B (Continued)
CMS Budget Neutrality Worksheets

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to *and* CNOM for additional hypothetical services that can be provided outside the IMD.	IMD Services Limit	Non-IMD Services CNOM Limit
Without Waiver (i.e., budget neutrality limit)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day · *Can* exclude months with ≤ 15 IMD inpatient days under managed care BN Expenditure Limit · PMPM cost × IMD MMs	PMPM Cost · Estimate of average CNOM service cost during Non-IMD MMs · Est. total CNOM service cost ÷ est. Non-IMD MMs · CNOM service cost can include capitated cost of IMD services Member Months · Non-IMD MM: Any month of Medicaid eligibility in which a person *could* receive a CNOM service that is not an IMD MM BN Expenditure Limit · PMPM cost × Non-IMD MMs
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	Expenditures Subject to Limit · All CNOM service costs with dates of service during Non-IMD MMs Reporting Requirements State must be able to identify and report: · Non-IMD MMs separate from IMD MMs · IMD CNOM costs separate from other MA costs

Glossary of Abbreviations

CNOM = expenditure authority (cost not otherwise matchable)
Hypo = hypothetical, i.e., optional services that could be included in the state plan but are instead being authorized in the 1115 using CNOM
IMD = institution for mental diseases
MA = medical assistance
MM = member month
SUD = substance abuse disorder
SMI = serious mental illness
SED = serious emotional disturbance

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD Overview

Notes

1. Date of service for capitation payments is the month of coverage for which the capitation is paid.
2. The IMD Services Limit and Non-IMD Services CNOM Limit are intended to be two distinct budget neutrality tests separately and independently enforced.
3. Services provided in an IMD "in lieu of" other allowable settings are excluded from this budget neutrality test (see below).
4. Some specific unallowable costs are detailed below (see STCs for additional exceptions and caveats).

Estimation for the IMD Services Limit

The IMD Services Limit represents the projected cost of medical assistance during months in which Medicaid eligible are patients at the IMD. These are the acceptable ways for the state to determine the PMPMs for the IMD Services Limit.

· States should present their most recent represenative year of historical data on overall MA costs for individuals with a SUD, SMI and/or SED diagnosis (or proxy) who received inpatient treatment those diagnoses (or could have received inpatient treatment if such services were available), to determine projected MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.

· The per user per month cost(s) are then projected forward using the President's Budget PMPM cost trend--and the projected per user per month costs will become the PMPMs for the IMD Services Limit.
· If the state has an existing comprehensive Medicaid demonstration with already calculated without waiver PMPMs, CMS will incorporate the PMPMs established in this workbook.
· States may also "top off" IMD Services Limit PMPMs with an additional estimated amount representing any additional CNOM services that affected individuals may also receive during IMD months.
· State may use Alternate PMPM Development in Historical tab for estimating expenditures (see 'Supplemental Methodology Document' requirement below).

Trends

PMPM trend rates will generally be the smoothed trend from the most recent President's Budget Medicaid trends and will be supplied to states by CMS.

· The President's Budget trends should be for the eligibility groups that are participating in the IMD demonstration; most often, these will be the Current Adults, New Adults, or a blend of Current and New Adults, to determine average MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.
· The per user per month costs are then projected forward using the President's Budget PMPM cost trend.
· The projected per user per month costs will become the PMPMs for the IMD Services Limit.

Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Services Limit(s) with associated PMPMs and member months, and one for the Non-IMD Services CNOM Limit and/or Non-Hypothetical CNOM Limit, as applicable.

· States may also develop single, or multiple, PMPMs for SUD, SMI and/or SED.

Member Month Non-Duplication

IMD Services Limit member month must be non-duplicative of Non-IMD Services CNOM Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months.

· This means that month of Medicaid eligibility for an individual cannot appear as both an IMD Services Limit member month and a Non-IMD Services CNOM Limit member month; it has to be one or the other, and likewise for IMD Services Limit member month and general comprehensive demonstration budget neutrality limit member months.
· IMD Services CNOM Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD Overview

Notes

State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and discussion - and choose the appropriate drop-downs corresponding to their data inputs.

- CMS will provide template instructions with this spreadsheet.

"In Lieu of" Services

States must not report expenditures for a capitation payment to a risk-based MCO or PIHP for an enrollee with a short-term stay in an IMD for inpatient psychiatric or substance use disorder services of no more than 15 days within the month for which the capitation payment is made is permissible under the regulation at §438.6(e) for MCOs and PIHPs to use the IMD as a medically appropriate and cost effective alternative setting to those covered under the State plan or ABP.

- This flexibility is referred to in the regulations as "in-lieu-of" services or settings and is effectuated through the contract between the state and the MCO or PIHP.
- For more information on "in leu of" servies, see "Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)" (August 2017).

Unallowable Costs

In addition to other unallowable costs and caveats outlined in the STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following :

- Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
- Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
- Costs for services provided to inmates of a public institution, as defined in 42 CFR 435.1010 and clause A after section 1905(a)(29), except if the individual is admitted for at least a 24 hour stay in a medical institution (see SMI/SED SMDL, p. 13).
- Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G .

Supplemental Methodology Document

The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the IMD Historical tab must be accompanied by a supplemental methodology and data sources document that fully describes, for each MEG, a complete break-out of all SUD, SMI and/or SED services--with descriptions of accompanying expenditures and caseloads.

- There should also be sections/headings in the methodology document which describe all other state data inputs (see 'State Data Inputs' above).

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD Historical

Representative Data Year:	2019
Type of State Years:	Calendar

SMI Adults, Ages 21 to 64

IMD Services MEG 1	2019
TOTAL EXPENDITURES	$6,335,957
ELIGIBLE MEMBER MONTHS	676
PMPM COST	$9,372.72

SUD Adults, Ages 18 to 64

IMD Services MEG 2	
TOTAL EXPENDITURES	$13,706,377
ELIGIBLE MEMBER MONTHS	3,292
PMPM COST	$4,163.54

SUD Adolescents, Ages 17 and Under

IMD Services MEG 3	
TOTAL EXPENDITURES	$928,996
ELIGIBLE MEMBER MONTHS	241
PMPM COST	$3,854.75

Continue MEGs from Above, As Needed

						2019				
			Managed Care PMPM (Replicate Column, as Necessary)			Choose "Included" from Drop-Down(s) to Link Services with MEG(s)				
Alternate Development: IMD Services + Non-IMD & Non-Hypo CNOMs	Estimated Total Expenditures for Medical Assistance Provided in an IMD that are:					CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
IMD Services	Currently State Plan FFS (e.g. Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)	Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)	Capitated PMPM for Currently Approved, non-IMD, State Plan or Other Title XIX Services	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost for All Services Provided in an IMD	IMD Services MEG 1	IMD Services MEG 2	IMD Services MEG 3	Non-IMD Services CNOM Limit MEG	Non-Hypothetical Services CNOM MEG
Service 1			$0		#DIV/0!					
Service 2			$0		#DIV/0!					
Service 3			$0		#DIV/0!					
Service 4			$0		#DIV/0!					
Service 5			$0		#DIV/0!					
Service 6			$0		#DIV/0!					
Service 7			$0		#DIV/0!					
Service 8			$0		#DIV/0!					
Service 9			$0		#DIV/0!					
Service 10			$0		#DIV/0!					
Service 11			$0		#DIV/0!					
Service 12			$0		#DIV/0!					
Add additional services, as necessary			$0		#DIV/0!					
Totals						$0.00	$0.00	$0.00	$0.00	$0.00

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD Without Waiver

PB Trend Rate(s) Used:

IMD Services MEG 1	4.80%
IMD Services MEG 2	4.80%
IMD Services MEG 3	4.80%
Non-IMD Services CNOM Limit MEG	

Start DY

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) 2021	2022	2023	2024	2025	TOTAL WOW
IMD Services MEG 1									
Eligible Member Months	n.a.	n.a.	676	749	793	841	892	945	
PMPM Cost	4.8%	21	$ 9,373	$ 10,174	$ 10,663	$ 11,174	$ 11,711	$ 12,273	
Total Expenditure				$ 7,616,048	$ 8,460,516	$ 9,398,618	$ 10,440,740	$ 11,598,408	$ 47,514,331
IMD Services MEG 2									
Eligible Member Months	n.a.	n.a.	3292	3,645	3,864	4,096	4,342	4,602	
PMPM Cost	4.8%	21	$ 4,164	$ 4,520	$ 4,736	$ 4,964	$ 5,202	$ 5,452	
Total Expenditure				$16,475,564	$ 18,302,381	$ 20,331,742	$ 22,586,107	$ 25,090,451	$ 102,786,245
IMD Services MEG 3									
Eligible Member Months	n.a.	n.a.	241	267	283	300	318	337	
PMPM Cost	4.8%	21	$ 3,855	$ 4,184	$ 4,385	$ 4,596	$ 4,816	$ 5,047	
Total Expenditure				$ 1,116,687	$ 1,240,505	$ 1,378,052	$ 1,530,850	$ 1,700,590	$ 6,966,683

Continue MEGs from Above, As Needed

Non-IMD Services CNOM Limit MEG									
Eligible Member Months	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	0.0%	0	$ -	$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD With Waiver

ELIGIBILITY GROUP	LAST HISTORIC YEAR	PB TREND RATE	DEMONSTRATION YEARS (DY) 2021	2022	2023	2024	2025	TOTAL WW
IMD Services MEG 1								
Eligible Member Months			749	793	841	892	945	
PMPM Cost	$ 9,373	4.8%	$ 10,174	$ 10,663	$ 11,174	$ 11,711	$ 12,273	
Total Expenditure			$ 7,616,048	$ 8,460,516	$ 9,398,618	$ 10,440,740	$ 11,598,408	$ 47,514,331
IMD Services MEG 2								
Eligible Member Months			3,645	3,864	4,096	4,342	4,602	
PMPM Cost	$ 4,164	4.8%	$ 4,520	$ 4,736	$ 4,964	$ 5,202	$ 5,452	
Total Expenditure			$ 16,475,564	$ 18,302,381	$ 20,331,742	$ 22,586,107	$ 25,090,451	$ 102,786,245
IMD Services MEG 3								
Eligible Member Months			267	283	300	318	337	
PMPM Cost	$ 3,855	4.8%	$ 4,184	$ 4,385	$ 4,596	$ 4,816	$ 5,047	
Total Expenditure			$ 1,116,687	$ 1,240,505	$ 1,378,052	$ 1,530,850	$ 1,700,590	$ 6,966,683
Continue MEGs from Above, As Needed								
Non-IMD Services CNOM Limit MEG								
Eligible Member Months	n.a.		0	0	0	0	0	
PMPM Cost	$ -	0.0%	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -

Main Budget Neutrality Test (i.e. NOT Hypothetical)

Non-Hypothetical Services CNOM MEG

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Eligible Member Months	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	0.0%		$ -	$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD Summary

Supplemetal Test #1: IMD Services Cost Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1	$7,616,048	$8,460,516	$9,398,618	$10,440,740	$11,598,408	$47,514,331
IMD Services MEG 2	$16,475,564	$18,302,381	$20,331,742	$22,586,107	$25,090,451	$102,786,245
IMD Services MEG 3	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
Continue MEGs from Above, As Needed						
TOTAL	$25,208,298	$28,003,402	$31,108,413	$34,557,697	$38,389,448	$157,267,259

With-Waiver Total Expenditures

	2021	2022	2023	2024	2025	TOTAL
IMD Services MEG 1	$7,616,048	$8,460,516	$9,398,618	$10,440,740	$11,598,408	$47,514,331
IMD Services MEG 2	$16,475,564	$18,302,381	$20,331,742	$22,586,107	$25,090,451	$102,786,245
IMD Services MEG 3	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
Continue MEGs from Above, As Needed						
TOTAL	$25,208,298	$28,003,402	$31,108,413	$34,557,697	$38,389,448	$157,267,259
Net Overspend	$0	$0	$0	$0	$0	**$0**

Supplemental Test #2: Non-IMD Services CNOM Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
Non-IMD Services CNOM Limit MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0

With-Waiver Total Expenditures

	2021	2022	2023	2024	2025	TOTAL
Non-IMD Services CNOM Limit MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0
Net Overspend	$0	$0	$0	$0	$0	**$0**

Appendix B (Continued)
CMS Budget Neutrality Worksheets

IMD Summary

Main Budget Neutrality Test (i.e. NOT Hypothetical)

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
Non-Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	**$0**

Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neutrality Test(s)' STC

SUD MEG(s)	Trend Rate	2021	2022	2023	2024	2025
IMD Services MEG 1	4.8%	$10,174	$10,663	$11,174	$11,711	$12,273
IMD Services MEG 2	4.8%	$4,520	$4,736	$4,964	$5,202	$5,452
IMD Services MEG 3	4.8%	$4,184	$4,385	$4,596	$4,816	$5,047
Continue MEGs from Above, As Needed						
Non-IMD Services CNOM Limit MEG	0.0%	$0	$0	$0	$0	$0
Main Test: With Waiver "Coster(s)" (Amendments Only)						
Non-Hypothetical Services CNOM MEG	0.0%	$0	$0	$0	$0	$0

IMD Caseloads

Projected IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	2021	2022	2023	2024	2025
IMD Services MEG 1	6.0%	749	793	841	892	945
IMD Services MEG 2	6.0%	3,645	3,864	4,096	4,342	4,602
IMD Services MEG 3	6.0%	267	283	300	318	337
Non-IMD Services CNOM Limit MEG			0	0	0	0
Non-Hypothetical Services CNOM MEG			0	0	0	0

Appendix C: Proof of Tribal Consultation & Public Notice

KEVIN S. CORBETT
CHIEF EXECUTIVE OFFICER

J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

I/T/U Public Notice 2020-02

March 18, 2020

RE: Oklahoma Health Care Authority Proposed Rule, State Plan and Waiver Amendments

Dear Tribal Representative:

The purpose of this letter is to notify you of proposed changes that will be reviewed at the tribal consultation meeting on April 1st, 2020 at 11 a.m. in the Oklahoma Health Care Authority's Charles Ed McFall Boardroom located at 4345 N Lincoln, Oklahoma City, OK., 73105. OHCA invites you to attend this meeting, and we welcome any comments regarding the proposed changes. The agency is committed to active communication with tribal governments during the decision-making and priority-setting process to keep you apprised of all proposed changes.

Enclosed are summaries of the current proposed rules, state plan and waiver amendments for your review. The summaries describe the purpose of each change.

Please note that these are only proposed changes and have not yet taken effect. Before implementation, proposed changes must obtain budget authorization and approval by the OHCA board, and when applicable, federal and governor approval must be obtained.

Additionally, OHCA posts all proposed changes on the agency's Policy Change Blog and the Native American Consultation Page. These public website pages are designed to give all constituents and stakeholders an opportunity to review and make comments regarding upcoming policy changes. To ensure that you stay informed of proposed policy changes, you may sign up for web alerts to be automatically notified when any new proposed policy changes are posted for comment.

OHCA values consultation with tribal governments and will provide your representatives a reasonable amount of time to respond to this notification. If you have any questions or comments about the proposed policy changes, please use the online comment system found on the Policy Change Blog and/or the Native American Consultation Page.

Sincerely,

Dana Miller
Director, Tribal Government Relations

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Proposed Rule, State Plan, and Waiver Amendments

Insure Oklahoma (IO) Termination — Revisions to several authorities, including but not limited to, the 1115(A) waiver, Title XXI state plan, and OHCA policy are necessary for the phase-out of the Insure Oklahoma program. IO enrollees will transition to the adult Medicaid expansion population or be encouraged to purchase health insurance on the federal marketplace.

SoonerPlan Termination — SoonerPlan is being terminated as adults currently being served by SoonerPlan will transition to the new adult Medicaid expansion population and will be eligible to receive more comprehensive services.

Removal of Hospital Presumptive Eligibility (HPE) for the Adult Expansion Population— HPE was erroneously chosen for adult expansion populations during changes in 2013 to comport with the Affordable Care Act (ACA), when the State did not seek authority to expand Medicaid. Changes to the State Plan are needed to correct the error. This item requests an expedited 30-day tribal consultation comment period.

Supplemental Hospital Offset Payment Program - OHCA is seeking to amend the Supplemental Hospital Offset Payment Program (SHOPP) assessment policy. According to current policy, the base year Medicare cost report, used to calculate the hospital assessment, is required to be updated every two years based on the hospital's fiscal year that ended two years prior. The proposed policy change will update the base year Medicare cost report, used to calculate the hospital assessment, to be every year based on the hospital's fiscal year that ended two years prior. This item requests an expedited 30-day tribal consultation comment period.

Adding the Newly Eligible Adult Group to the Existing 1115 Waiver – The OHCA is seeking to add newly eligible adults as a covered group under the existing 1115 waiver in order to allow services to be provided by the PCMH service delivery model. Additionally, adding the newly eligible adult population to the existing 1115 waiver will waive retroactive eligibility for this population. This item requests an expedited 30-day tribal consultation comment period.

Increase Care Coordination Rate for PCMH American Indian/Alaskan Native (AI/AN) Providers – The OHCA is seeking to increase the care coordination rate for AI/AN Patient Centered Medical Home (PCMH) providers. The care coordination rate will be increased to $27.25 per member per month with successive annual increases throughout the waiver approval period. This item requests an expedited 30-day tribal consultation comment period.

Section 5022 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act— The proposed revisions will update policy to demonstrate compliance with the requirement of Section 5022 of the SUPPORT Act in areas related to coverage of developmental and behavioral health related screenings and applicable preventive services.

Institutes for Mental Disease (IMD) Waiver- The OHCA and Department of Mental Health and Substance Abuse Services (ODMHSAS) are proposing to submit a serious mental illness (SMI)/substance use disorder (SUD) section 1115 waiver to waive the exclusion of Medicaid reimbursement for services provided to individuals within IMD. This waiver will allow federal financial participation (FFP) for Medicaid-eligible adults, ages 21-64, to receive acute inpatient psychiatric care or residential substance abuse treatment in facilities with 16 beds or more (IMDs). These services are not intended to decrease or replace services in less restrictive settings but rather to support the continuum of care.

Pharmacists Medication Therapy Services – The OHCA is seeking federal and state authority to allow contracted, qualified, and trained pharmacists to provide medication therapy services. Medication therapy services optimize therapeutic outcomes for members and reduce incidence of morbidity associated with chronic conditions or inappropriate use of medications.

Executive Order 2020-03 - The OHCA will revoke sections that are duplicative, no longer applicable, or can be combined into other sections of Agency policy. Revocation of aforementioned policies are an effort to be in compliance with Executive Order 2020-03, also known as the "1-in-2-out" requirement. None of the sections being revoked will have any impact to members, providers, or the SoonerCare program.

Tribal Consultation Meeting Agenda
11 a.m., April 1
Teleconference

ATTENDANCE

On-Call: Tribal Partners	On-Call: OHCA Staff
1. Melanie Fourkiller – Choctaw Nation	1. Dana Miller
2. Yvonne Myers – Citizen Potawatomi Nation	2. Johnney Johnson
3. Tenesha Washington – OKCIC	3. Latrita Bradford
4. Brenda Teel – Chickasaw Nation	4. Vivian Morris
5. Rhonda Beaver – Muscogee Creek Nation	5. Traylor Rains
6. Robyn Sunday-Allen – OKCIC	6. Stephanie Mavredes
7. Renee Hogue – Chickasaw Nation	7. Melinda Thomason
8. Sandra Sealey – OCAO IHS	8. Sandra Puebla
9. Tracie Patten – OCAO IHS	9. Amy Bradt
10. Angela Fish – Muscogee Creek Nation	10. Ashley Johnson
11. Melissa Gower – Chickasaw Nation	11. Kasie McCarty
12. Brian Wren – Choctaw Nation	12. Maria Maule
	13. Vanessa Andrade
	14. April Anonsen
	15. Christina Foss
	16. Sasha Teel
	17. Bert Bailey
	18. Terry Cothran

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Admin: 405-522-7300
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ABBREVIATED PUBLIC NOTICE

Pursuant to Section 431.408 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) is required to provide public notice of its intent to submit a new 1115(a) waiver request to the Centers for Medicare & Medicaid Services (CMS) to reimburse for short-term residential treatment or inpatient stabilization services in an institution for mental disease (IMD); the waiver request will be effective for a five-year period.

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THE BLACK CHRONICLE

PROOF OF PUBLICATION

In the _____ Court of _____ Oklahoma

STATE OF OKLAHOMA

STATE OF OKLAHOMA, _____)

COUNTY OF **OKLAHOMA**)

RUSSELL M. PERRY, of lawful age, being duly sworn upon oath, deposes and says: That he is the **PUBLISHER** of the ***The Black Chronicle***, weekly newspaper printed and published in the city of Oklahoma City, County of Oklahoma, State of Oklahoma, and has personal knowledge of the facts hereinafter stated.

That a printed notice, copy of which is here to attached, was published in the regular and entire issue of said newspaper, and not in any supplement thereof, for ONE consecutive WEEK, the first publication thereof being made on THURSDAY, the 30th day of APRIL, 2020 and the last publication on the 30th day of APRIL, 2020.

That said newspaper had been continuously and uninterruptedly published in said county during a period of more than one hundred and four (104) weeks consecutively and immediately prior to the first publication of the attached notice or advertisement; that it has entrance into the United States mails in the city and county where published; that said newspaper comes within all of the prescriptions and requirements of Title 25 Oklahoma Statutes of 1941, Section 102, and meets all other requirements of the laws of the State of Oklahoma with reference to legal publications.

Russell Perry

Subscribed and sworn to before me this 1st day of May, 2020

Tiffany Cooper
Notary Public

My Commission Expires

TIFFANY COOPER
Notary Public, State of Oklahoma
Commission # 19000485
My Commission Expires 01-14-2023

Publication fee $_____

The Black Chronicle
CLASSIFIED

The Black Chronicle
P.O. Box 17488 1528 N.E. 23rd Street
OKLAHOMA CITY, OKLAHOMA 73136
DISPLAY (405) 424-4986
CLASSIFIED (405) 424-9525
FAX (405) 424-5708

1-13 Words	$10.75
14-20 Words	$12.75
21-27 Words	$14.05
28-34 Words	$16.00
35-41 Words	$18.00

Advertising Deadline, Tuesdays at 1 p.m.!
An additional 40 cents per word is charged for ads over 41 words.

Advertising – 1

ADVERTISE STATEWIDE Put your message where it matters most – in Oklahoma newspapers. We can place your ad in 158 newspapers. For more information or to place an ad, contact Landon Cobb at (405) 499-0022 or toll-free in OK at 1-888-815-2672.

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OLD GUITARS WANTED! Larry bring$ ca$h for vintage USA guitars, tube amps, banjos, mandolins, etc. Fender, Gibson, Martin, Gretsch, others Call or text 918-288-2222. www.stringswest.com

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Roll-in Showers for qualified **Veterans Call Now!**
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Needing Credit Repair?
1415 NW 43rd,
OKC, OK 73118
405-217-3933
www.ccgstl.com

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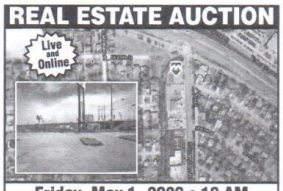
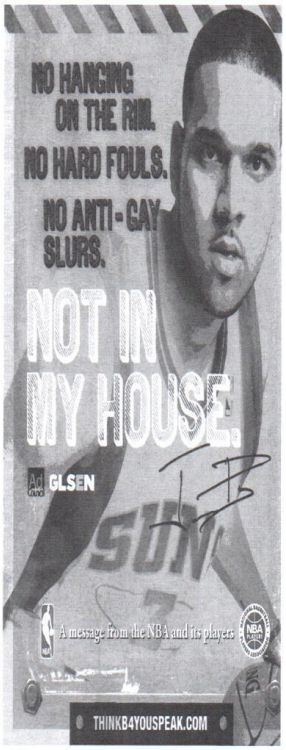
REAL ESTATE AUCTION

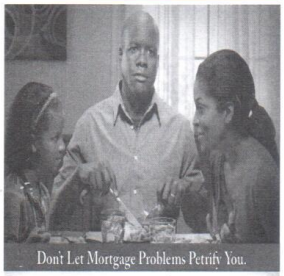


Friday, May 1, 2020 • 10 AM
1101 S. Sunnylane, Del City, OK - *Seller Don Pugh*
Zoned Commercial - *Between Reno and 15th St. Right off of I-40 exit Sunnylane.*
Property is on the corner of Sunnylane and I-40. Excellent building site with I-40 visibility. Great Investment. Drive by anytime. Closing at Old Republic Title. Taxes $1,022 for 2019.
See **www.KenCarpenterAuction.com**
Ken Carpenter 405-620-1524

REAL ESTATE AUCTION

Sat. May 2, 2020 • 10:00am
14900 W. Funston, Yukon, OK 73099
2 Bed, 1 Bath, 1312 sqft rock home on 1 acre mL Yukon school, 10 year old roof, well & septic. On the end of dead end road. 30x40 shop with concrete floor. Previous tenant had 1 horse on property. Large shade trees. Lots of porch on front & back. New windows in last ten years. Country style home. Lots of possibilities. Nice quiet Richland community. Just north of Britton Road on Richland Rd. Call Ken for your private showing.
See www.KenCarpenterAuction.com for pictures & bidding.
Terms: "AS IS" 10% down day of auction. Close in 30 days. 2019 taxes $1,225.
Ken Carpenter Auction LLC. 405-620-1524





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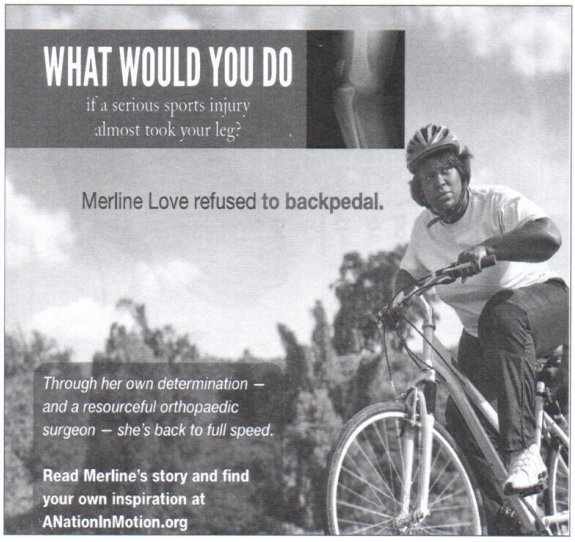

TULSA WORLD

P.O. Box 1770 Tulsa, Oklahoma 74102-1770 | tulsaworld.com

Account Number
1013049

AEI ADVERTISING
SARAH WOODS
772 E. MOUNTAIN SAGE DRIVE
PHOENIX, AZ 85048

Date
May 01, 2020

Date	Category	Description	Ad Size
05/01/2020	Legal Notices	ABBREVIATED PUBLIC NOTICE	2 x 64.00 CL

640124
Published in the Tulsa World, Tulsa County, Oklahoma, May 1, 2020

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Affidavit of Publication

I, Melissa Marshall, of lawful age, am a legal representative of the Tulsa World of Tulsa, Oklahoma, a daily newspaper of general circulation in Tulsa County, Oklahoma, a legal newspaper qualified to publish legal notices, as defined in 25 O.S. § 106 as amended, and thereafter, and complies with all other requirements of the laws of Oklahoma with reference to legal publication. That said notice, a true copy of which is attached hereto, was published in the regular edition of said newspaper during the period and time of publication and not in a supplement, on the DATE(S) LISTED BELOW

05/01/2020

Newspaper reference: 0000640124

M. Marshall
Legal Representative

Sworn to and subscribed before me this date: MAY 04 2020

Valerie L Praytor
Notary Public

My Commission expires 4-7-24

NOTARY SEAL PUBLIC
VALERIE L. PRAYTOR
Notary Public
State of Oklahoma
Commission #20003824 Exp: 04/07/24

La Semana
4/30/20

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NORMAN TRANSCRIPT
4/30/20

PROOF OF PUBLICATION

~~In the District Court of Cleveland County,~~
~~State of Oklahoma~~

OKHCA Public Notice

Affidavit of Publication

State of Oklahoma, County of Cleveland, ss:
I, the undersigned publisher, editor or Authorized Agent of the Norman Transcript, do solemnly swear that the attached advertisement was published in said paper as follows:

1st Publication April 30, 2020

2nd Publication_____

3rd Publication_____

4th Publication_____

That said newspaper is Daily, in the city of Norman, Cleveland County, Oklahoma, a Daily newspaper qualified to publish legal notices, advertisements and publications as provided in Section 106 of Title 25, Oklahoma Statutes 1971, as amended, and complies with all other requirements of the laws of Oklahoma with reference to legal publications.

That said Notice, a true copy of which is attached hereto, was published in the regular edition of said newspaper during the period and time of publications and not in a supplement, on the above noted dates.

Signature

Subscribed and sworn before me on this 29 day of April, 2020.

My commission expires 09-22-2021

Notary Public Commission # 17008825

PAY TO:
The Norman Transcript
P.O. Drawer 1058
Norman, OK 73070

~~A copy of this affidavit of publication was delivered to the Office of the Cleveland County Court Clerk on April 29, 2020.~~

Please include the case number on your check.

MARK MILLSAP NOTARY PUBLIC No 17008825 Expires Sept 22, 2021 STATE OF OKLAHOMA

(Published in The Norman Transcript April 30, 2020, 1t)

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OKLAHOMAN 5/1/20

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STATE OF OKLAHOMA, } SS.
COUNTY OF OKLAHOMA

Affidavit of Publication

Terri Roberts, of lawful age, being first duly sworn, upon oath deposes and says that she/he is the Classified Legal Notice Admin, of GateHouse Media Oklahoma Holdings, Inc, a corporation, which is the publisher of *The Oklahoman* which is a daily newspaper of general circulation in the State of Oklahoma, and which is a daily newspaper published in Oklahoma County and having paid general circulation therein; that said newspaper has been continuously and uninterruptedly published in said county and state for a period of more than one hundred and four consecutive weeks next prior to the first publication of the notice attached hereto, and that said notice was published in the following issues of said newspaper, namely:

AEI ADVERTISING
80952

AdNumber	Publication	Page	Date
0000568131-01	OC- The Oklahoman	B7	05/01/2020

Terri Roberts
Agent: Terri Roberts Date: 05/04/2020

Subscribed and sworn to be me before this date : 05/04/2020

Royce A. Parkhurst
Notary: Royce A. Parkhurst Date: 05/04/2020

ROYCE A. PARKHURST NOTARY # 08008272 EXP. 08/21/20 PUBLIC STATE OF OKLAHOMA

772 E MOUNTAIN SAGE DRIVE, PHOENIX, AZ 85048, USA 0000568131

The Lawton Constitution
P.O. Box 2069-L
Lawton, OK 73502
580-585-5000

Proof of Publication

IN THE DISTRICT COURT OF COMANCHE COUNTY OKLAHOMA

State of Oklahoma, County of Comanche
Abbreviated Public Notice

I, DAVID R. STRINGER, of lawful age, being duly sworn upon oath, deposes and says: That I am the Publisher of The Lawton Constitution, a daily newspaper printed and published in the city of Lawton, County of Comanche, and state of Oklahoma, and that the advertisement above referred to, a true and the publication dates listed below.

Publication The Lawton Constitution: 05/01/20.

That said newspaper has been published continuously and uninterruptedly in said county during a period of one hundred and four consecutive weeks prior to the publication of the attached notice or advertisement: that it has been admitted to the United States mail as second-class mail matter, that it has a general paid circulation, and publishes news of general interest, and otherwise conforms with all of the statues of the State of Oklahoma governing legal publications.

Signed: _____
Signature

SUBSCRIBED and sworn to be me this day of
26th day of May, 2020

NOTARY PUBLIC State of OK
TONI WILSON
Comm. # 05011169
Expires 12-12-2021

_____
Notary Public

Acct #51016 **Ad #738121**

Published in
The Lawton Constitution
May 1, 2020

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NOTICE OF PUBLIC COMMENT PERIOD FOR IMD WAIVER

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https://okhca.zoom.us/webinar/register/WN_g22DISEpRN2pJw-ZsZHOPQ

Prior to finalizing the proposed 1115 SMI/SUD IMD waiver, the OHCA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to CMS.

SMI/SUD IMD WAIVER PROPOSAL SUMMARY AND OBJECTIVES

Beginning no sooner than October 1, 2020, and contingent upon CMS approval, the 1115 IMD waiver for serious mental illness (SMI) and substance use disorder (SUD) will further provide access to mental health and substance use treatment by allowing Medicaid coverage and reimbursement for services provided to eligible adults with SMI/SUD, ages 21-64, within an IMD. Additionally, individuals under the age of 21 will be eligible to receive residential SUD services within an IMD. The state also plans to transition current congregate care facilities for children in state custody to Qualified Residential Treatment Programs (QRTPs) October 1, 2021, and through this waiver seeks federal authority to reimburse for short-term stays of less than 60 days in QRTPs determined to be IMDs. This waiver seeks to improve quality, accessibility, and outcomes of SMI/SUD treatment services in the most cost-effective manner possible. Through this demonstration, Oklahoma seeks to support the overall health and long-term successful outcomes of individuals with SMI and SUD. The overarching premise this demonstration supports is that, if the full continuum of care is provided, individuals who access the system will receive the least restrictive, most effective provision of services, which is continually evaluated so that individuals' changing needs translate to changing services to meet those needs.

The SMI/SUD IMD waiver proposal will implement policies that will improve the current system's capacity to appropriately address acute behavioral health needs, improve rates of morbidity and mortality for covered populations, and decrease utilization of less appropriate services. The proposed waiver has separate goals for targeting substance use disorders and for addressing SMI/SED.

Goals targeting substance use disorders:

- Increase rates of identification, initiation, and engagement in treatment;
- Increase adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions among beneficiaries.

Goals addressing SMI/SED:

- Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings;
- Reduce preventable readmissions to acute care hospitals and residential settings;
- Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care; and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

ELIGIBILITY

Individuals eligible under the SMI/SUD IMD waiver include mandatory and/or optional eligibility groups approved for full Medicaid coverage who are between the ages of 21-64 and provided with short-term residential treatment or inpatient stabilization services in an IMD. Additionally, Medicaid eligible individuals under 21 years of age who receive SUD services within an IMD are also eligible under the waiver.

ENROLLMENT AND FISCAL PROJECTIONS

SoonerCare currently covers approximately 785,000 total individuals within all programs. Medicaid expansion is anticipated to add approximately 128,703 individuals in its first year, beginning July 1, 2020. Subsequent implementation of the Healthy Adult Opportunity (HAO) waiver starting July 1, 2021, is anticipated to bring enrollment of newly eligible adults to 144,285 in its first year and is expected to rise in subsequent years to 151,624. Because the HAO waiver exempts individuals with SMI receiving treatment and individuals participating in addiction treatment programs from the community engagement and cost sharing requirements, it is not expected that enrollment for those populations will be significantly impacted by those requirements.

This 1115 SMI/SUD IMD waiver is not anticipated to impact SoonerCare enrollment over the course of the five-year demonstration, as there are no waiver-specific eligibility criteria included. Additionally, the SMI/SUD IMD demonstration will have no impact on Medicaid eligibility and is expected to have no fiscal impact, as depicted in the table below.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1: SMI Adults, Ages 18 to 64	$55,488,928	$61,641,545	$68,476,390	$76,069,073	$84,503,637	$346,179,572
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$44,712,238	$49,669,948	$55,177,335	$61,295,347	$68,091,765	$278,946,631
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
TOTAL	$101,317,852	$112,551,998	$125,031,776	$138,895,269	$154,295,991	$632,092,887

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1: SMI Adults, Ages 18 to 64	$55,488,928	$61,641,545	$68,476,390	$76,069,073	$84,503,637	$346,179,572
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$44,712,238	$49,669,948	$55,177,335	$61,295,347	$68,091,765	$278,946,631
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
TOTAL	$101,317,852	$112,551,998	$125,031,776	$138,895,269	$154,295,991	$632,092,887

Net Overspend	$0	$0	$0	$0	$0	**$0**

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

Covered Benefits
Current Medicaid beneficiaries have access to a robust behavioral health service system. This demonstration seeks to enhance the continuum of care by adding inpatient, residential substance use disorder, and facility-based crisis stabilization services furnished at an IMD to the Medicaid service system. This enhancement will promote the use of the most effective, appropriate services to support long-term successful outcomes.

Applicable Copays
This waiver will not impact or add any cost sharing requirements. Currently, the state's Medicaid program includes copays for non-exempt individuals covered under Title XIX. Adults are subject to inpatient copays, which are currently $10/day (up to $75 max). Cost sharing has a cap of 5% of the aggregate household income. This cap is based on the household's total gross income and is applied monthly; once the household reaches their 5% cap in a month, no additional cost sharing is assessed in that month.

Beginning July 1, 2021, the HAO waiver will implement nominal cost sharing through premiums and copays for newly eligible adults. However, individuals with SMI or SUD are excluded from these cost sharing requirements.

Cost Sharing Exemptions
Individuals exempt from cost sharing include pregnant women and individuals who are American Indian/Native American.

Delivery System
The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work collaboratively to provide a wide array of behavioral health services for Oklahomans. Medicaid compensable inpatient services are largely administered by the OHCA, while Medicaid compensable outpatient behavioral health services and other state-funded supports are largely administered by the ODMHSAS. A combined payer system consolidates eligibility determinations, claims, authorizations, and outcomes data for publicly funded services, including both Medicaid compensable and state-funded services.

Services and supports are currently available statewide through a network of private and government-operated programs that will also serve as providers for this waiver. These include facility-based crisis centers, psychiatric hospitals, residential substance use disorder (SUD) treatment providers, and Qualified Residential Treatment Programs (QRTPs), when the provider(s) also qualifies as an IMD.

This waiver will not change the Medicaid delivery system. The State of Oklahoma is seeking to establish delivery system reforms through the HAO waiver, including a unique managed care delivery system that builds upon the current primary care case management system. This new delivery system will focus on care coordination, behavioral health integration, and value-based payment methodologies for providers. The additional benefits this SMI/SUD waiver seeks authorization to add to the service array will be included in this unique managed care delivery system.

Payment Rates for Services
Payment methodologies will be consistent with those approved in the Medicaid State Plan, where applicable. Inpatient and residential IMD services will be reimbursed via a per diem methodology, with crisis stabilization reimbursed through an hourly payment structure. Under the authority of this waiver, the state seeks to promote the outcomes and goals of the demonstration through the implementation of a value-based payment structure

for all Medicaid-enrolled residential SUD providers. The state plans to implement a system whereby providers must meet certain quality benchmarks in order to receive a 10% bonus to their per diem rate.

The state seeks flexibility to modify the parameters of this payment structure throughout the demonstration period in order make improvements as experience is gained and outcomes data is collected.

HYPOTHESIS AND EVALUATION

The SMI/SUD IMD waiver will be subject to an independent evaluation that investigates the outcomes of the following goals and hypothesis.

Substance Use Disorder

Objective/Goal	**Hypothesis**	**Evaluation Parameters/Methodology**
Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?		
GOAL 1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	**Hypothesis 1.** The demonstration will increase the percentage of beneficiaries who are referred to and engage in treatment for OUD and other SUDs.	**Data Sources:** • Claims data • Provider survey • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 2. Increased adherence to and retention in treatment for OUD and other SUDs.	**Hypothesis 2.** The demonstration will increase the percentage of beneficiaries who adhere to treatment of OUD and other SUDs.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance • T-Test
GOAL 3. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	**Hypothesis 3.** The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	**Data Sources:** • Claims data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Do enrollees receiving SUD services experience improved health outcomes?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 4. Improved access to care for physical health conditions among beneficiaries.	**Hypothesis 4.** The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.	**Data Sources:** • Claims data • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.	**Hypothesis 5.** Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?		
GOAL 6. Reduction in overdose death, particularly those due to opioids.	**Hypothesis 6**. The demonstration will decrease the rate of overdose deaths due to opioids.	**Data Sources:** • Claims data • Administrative data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance

Serious Mental Illness

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings? How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.	**Hypothesis 1.** The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.	**Data Sources:** • Claims data • Medical records or administrative records • Interviews or focus groups **Analytic Approach:** • Difference-in-differences model • Subgroup analyses • Descriptive quantitative analysis • Qualitative analysis
Evaluation Question: Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings? How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?		
GOAL 2. Reduced preventable readmissions to acute care hospitals and residential settings.	**Hypothesis 2.** The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	**Data Sources:** • Claims data • Medical records • Beneficiary survey **Analytic Approach:** • Difference-in-difference models • Qualitative analysis • Descriptive quantitative analysis
Evaluation Questions: To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state? To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs; psychiatric hospitals; and residential treatment settings throughout the state.	**Hypothesis 3.** The demonstration will result in improved availability of crisis stabilization services throughout the state.	**Data Sources:** • Annual assessments of availability of mental health services • AHRF data • NMHSS survey • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis
Evaluation Questions: Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health needs? To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED? To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services? How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics? Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED improve under the demonstration?		
GOAL 4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care.	**Hypothesis 4.** Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	**Data Sources:** • Claims data • Annual assessments of availability of mental health services • AHRF • NMHSS survey • Administrative data • URS • Medical records **Analytic Approach:** • Descriptive quantitative analysis • Chi squared analysis • Difference-in-differences model
Evaluation Questions: Does the demonstration result in improved care coordination for beneficiaries with SMI/SED? Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities? How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Hypothesis 5.** The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Data Sources:** • Claims data • Medical records • Interviews or focus groups • Facility records **Analytic Approach:** • Difference-in-differences model • Descriptive quantitative analysis • Qualitative analysis

WAIVER AND EXPEDITURE AUTHORITY

Oklahoma seeks expenditure authority under Section 1115(a) for services provided to otherwise eligible individuals under age 21 in QRTPs and for residential substance use disorder stays that qualify as IMDs. Additionally, the state seeks expenditure authority for enrollees ages 21-64 for short-term acute psychiatric stays, residential substance use disorder stays, and facility-based crisis stabilization stays in facilities that qualify as IMDs.

This demonstration will include all eligible individuals ages 21-64 (and under 21 where applicable) who are eligible for Medicaid and does not impose any additional eligibility criteria. Oklahoma is seeking to expand Medicaid eligibility through a submitted state plan amendment, with an effective date of July 1, 2020.

Interested persons may visit www.okhca.org/PolicyBlog to view a copy of the proposed waiver, public notice(s), location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates. Due to the current public health emergency and the associated social distancing guidelines, persons wishing to present their views in writing or obtain copies of the proposed waiver may do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver will be accepted by contacting OHCA as indicated. Comments submitted through the OHCA policy blog will be available for review online at www.okhca.org/PolicyBlog. Other written comments are available upon request at federal.authorities@okhca.org. Comments will be accepted May 1-31, 2020.

SPA 01-13

State Plan Change for Reimbursement of certain Outpatient Drugs

Circulated Date: 03/22/2013

OHCA Comment Due Date: 04/04/2013

SoonerCare and 1115 Demonstration Waiver Amendments

1115(a) Institution for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD)

The OHCA and Department of Mental Health and Substance Abuse Services are proposing to submit the 1115 IMD waiver for serious mental illness (SMI) and substance use disorder (SUD) to further provide access to mental health and substance use treatment by allowing Medicaid coverage and reimbursement for services provided to eligible adults with SMI/SUD, ages 21-64, within IMDs. Additionally, individuals under the age of 21 will be eligible to receive residential SUD services within an IMD and a new IMD provider type for qualified residential treatment programs (QRTP) will be established under the proposed waiver. The waiver will request coverage for medically necessary residential substance use disorder treatment, facility-based crisis stabilization, and inpatient treatment services within IMDs. The waiver will also seek to improve outcomes, quality, and accessibility of SMI/SUD treatment services in a cost-effective manner. Through this demonstration, Oklahoma seeks flexibility to improve access to quality behavioral health care to support the overall health of individuals diagnosed with SMI and/or SUD.

As of today, OHCA will be holding virtual public hearings on this proposal as follows:

Virtual Public Hearing
May 6, 2020, at 3 p.m.
Register for Zoom Public Hearing:
https://okhca.zoom.us/webinar/register/WN_KHdFenQIS6GEeBZNwLfXHg

Virtual Public Hearing
May 8, 2020, at 3 p.m.
Register for Zoom Public Hearing:
https://okhca.zoom.us/webinar/register/WN_g22DISEpRN2pJw-ZsZHOPQ

Interested persons may view a copy of the proposed waiver, public notice(s), location and times of public hearings, here. Any public comments on the proposal, supplemental information, and updates may also be made here. Please view the waiver in its entirety here: Institutes for Mental Disease Waiver. Due to the current public health emergency and the associated social distancing guidelines, persons wishing to present their views in writing or obtain copies of the proposed waiver may do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver will be accepted by contacting OHCA as indicated. Comments submitted through the OHCA policy blog will be available for review online at www.okhca.org/PolicyBlog. Other written comments are available upon request at federal.authorities@okhca.org. Comments will be accepted May 1-31, 2020.

Please view additional documents here:

1. OK 1115 Serious Mental Illness (SMI) Availability Assessment

2. OK 1115 Serious Mental Illness (SMI) Availability Assessment (Excel)

3. OK 1115 Substance Use Disorder (SUD) Availability Assessment

4. OK 1115 Substance Use Disorder (SUD) Availability Assessment (Excel)

From: OHCAWebAlerts@okhca.org
To: Kasie McCarty
Subject: This is a Web Alert from the Native American Consultation Page
Date: Friday, May 1, 2020 4:22:22 PM

The "Native American Consultation Page" page has been changed.

We sent you this e-mail because you subscribed to be notified when a change has been made to this section.

Please visit the website to review and/or comment on the proposed waiver listed below:

- 1115(a) Institution for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD)

Please visit the website to review the public notice listed below:

- 1115(a) Institution for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD)

Read More: https://www.okhca.org/ProposedChanges.aspx

If you would like to unsubscribe from ALL OHCA Web Alert e-mails, click here - removal, or write to us at Oklahoma Health Care Authority, Attn: Communication Services, 4345 N. Lincoln, Oklahoma City, OK 73105

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In no event shall Oklahoma Health Care Authority be liable for any direct, special, indirect, or consequential damages, or any other damages of whatever kind resulting from whatever cause, including, but not limited to, loss of use, loss of profits, loss of data, or any other type of damage, tangible or intangible in nature, whether in an action under theories of contract, tort or otherwise, arising out of or in any relating to the use of performance of the OHCA Web alerts e-mail system.

From: OHCAWebAlerts@okhca.org
To: Kasie McCarty
Subject: This is a Web Alert From Proposed Rule Changes
Date: Friday, May 1, 2020 4:22:01 PM

The "Proposed Policy Changes" page has been changed.

We sent you this e-mail because you subscribed to be notified when a change has been made to this section.

Please visit the website to review and/or comment on the proposed waiver listed below:

- 1115(a) Institution for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD)

Please visit the website to review the public notice listed below:

- 1115(a) Institution for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD)

Read More: https://www.okhca.org/PolicyBlog.aspx

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In no event shall Oklahoma Health Care Authority be liable for any direct, special, indirect, or consequential damages, or any other damages of whatever kind resulting from whatever cause, including, but not limited to, loss of use, loss of profits, loss of data, or any other type of damage, tangible or intangible in nature, whether in an action under theories of contract, tort or otherwise, arising out of or in any relating to the use of performance of the OHCA Web alerts e-mail system.

OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

VIRTUAL PUBLIC HEARING

Agenda

Wednesday May 6, 2020

3 p.m.

1. **Welcome**

2. **Presentation of Proposed Waiver**
   - **Traylor Rains, Deputy State Medicaid Director**
   - **Melissa Miller, Director of Medicaid Behavioral Health Policy and Planning ODMHSAS**

   1115(a) Institution for Mental Disease (IMD) Waiver for SMI/SUD
   Beginning no sooner than Oct. 1, 2020, and contingent upon CMS approval, OHCA and the Department of Mental Health and Substance Abuse Services are seeking to establish an 1115(a) demonstration waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD) to provide coverage and federal financial participation for Medicaid-eligible adults, ages 21-64, in acute inpatient psychiatric care or residential substance abuse treatment facilities with 16 beds or more. These services are not intended to decrease or replace services in less restrictive settings but rather to support the continuum of care. Additionally, individuals under the age of 21 will be eligible to receive residential SUD services within an IMD and a new IMD provider type for qualified residential treatment programs (QRTP) will be established under the new proposed waiver. The proposed waiver will improve quality, accessibility and outcomes of SMI/SUD treatment services in the most cost-effective manner possible.

3. **Public Comment and Q&A**

4. **Adjourn**

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
okhca.org
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-522-0114

Kevin Corbett | Chief Executive Officer

J. Kevin Stitt | Governor

Virtual Public Hearing
3 p.m., May 6

ATTENDANCE
An additional 2 participants attended the meeting via dial-in.

First Name	Last Name
3. Erica	Cook
4. Rick	Snyder
5. Tracy	Leeper
6. Brittany	Hayes
7. Eric	Sachau
8. Zack	Stoycoff
9. BerThaddaeus	Bailey
10. Diane	Reagle
11. Lisa	Macias
12. Christina	Foss
13. Pamela	Leyhe
14. Michael	Chongwa
15. Stephanie	Mavredes
16. Vanessa	Andrade
17. Sasha	Teel
18. Coby	Nirider
19. Heather	Joseph
20. Margaret	den Harder

OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

VIRTUAL PUBLIC HEARING

Agenda

Friday May 8, 2020

3 p.m.

1. **Welcome**

2. **Presentation of Proposed Waiver**
   - **Traylor Rains, Deputy State Medicaid Director**
   - **Melissa Miller, Director of Medicaid Behavioral Health Policy and Planning ODMHSAS**

   1115(a) Institution for Mental Disease (IMD) Waiver for SMI/SUD
   Beginning no sooner than Oct. 1, 2020, and contingent upon CMS approval, OHCA and the Department of Mental Health and Substance Abuse Services are seeking to establish an 1115(a) demonstration waiver for Serious Mental Illness (SMI) and Substance Use Disorder (SUD) to provide coverage and federal financial participation for Medicaid-eligible adults, ages 21-64, in acute inpatient psychiatric care or residential substance abuse treatment facilities with 16 beds or more. These services are not intended to decrease or replace services in less restrictive settings but rather to support the continuum of care. Additionally, individuals under the age of 21 will be eligible to receive residential SUD services within an IMD and a new IMD provider type for qualified residential treatment programs (QRTP) will be established under the new proposed waiver. The proposed waiver will improve quality, accessibility and outcomes of SMI/SUD treatment services in the most cost-effective manner possible.

3. **Public Comment and Q&A**

4. **Adjourn**

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
okhca.org
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-522-0114

Virtual Public Hearing
3 p.m., May 8

ATTENDANCE
An additional 5 participants attended the meeting via dial-in.

First Name	Last Name
6. Sasha	Teel
7. Julie	Thrash
8. Sandra	Puebla
9. Stephanie	Mavredes
10. Mark	DeClerk
11. Mary Ann	Dimery
12. Spencer	Kusi
13. Nola	Harrison
14. Diane	Bedell
15. BerThaddaeus	Bailey
16. Kasie	McCarty
17. Nichole	Burland
18. LaShonda	Phillips
19. Crystal	Stimac
20. Brittany	Hayes
21. Tony	Russell
22. Scott	Tohlen

Appendix D: Standard Funding Questions

i. **Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan.**

Do providers receive and retain the total Medicaid expenditures claimed by the State(includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local government entity or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or Percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e. general fund, medical services account, etc.)

Yes, providers receive and retain 100 percent of the total Medicaid expenditures.

ii. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan.**

Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

a. A complete list of the names of entities transferring or certifying funds:
Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)
b. The operational nature of the entity (state, county, city, other):
State Government Agency.
c. The total amounts transferred or certified by each entity:
$672,431.35/month state share for SUD/SMI services provided in an IMD
d. Clarify whether the certifying or transferring entity has general taxing authority:

No general taxing authority.

e. Whether the certifying or transferring entity receives appropriations (identify level of appropriations):
Yes.

State appropriations are made from the legislature to ODMHSAS and the source of the State Share for the Medicaid payment is provided using IGTs to the Oklahoma Health Care Authority (OHCA).

The estimated total average monthly expenditure for SUD/SMI services provided in an IMD is $2,100,691.50; state share amount $672,431.35. The Medicaid agency receives the IGT by the 5th working day of the month prior to making the Medicaid payment.

iii. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Not applicable, these payments will not be State Plan supplemental payments.

vii. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

Not applicable.

viii. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the federal share of the excess to CMS on the quarterly expenditures report?

No governmental provider receives payments that exceed their reasonable costs of providing services.